

PHILADELPHIA MEDICAL TIMES.

PHILADELPHIA, MAY 15, 1886.

AMERICAN MEDICAL ASSOCIATION.

THE Thirty-Seventh Annual Session of the American Medical Association was held in the city of St. Louis, Missouri, May 4, 5, 6, and 7, 1886. The Exposition-Building, with its two large public entertainment-halls and convenient smaller rooms, appeared admirably adapted for the meeting of such a convention as this Association, as it accommodated all the Sections under one roof. The number of delegates, permanent members, and members by application, amounted to eleven hundred and sixty-three. All things considered, this may be regarded as one of the most successful meetings of the Association which has ever been held. Contrary to the expectation of many, and perhaps to the disappointment of some, there was very little of the factional spirit manifested which had marred the harmony of the previous session. The report of the Committee upon Arrangements for the International Medical Congress, which was expected to renew the fight of last year, was received and adopted without the slightest opposition. The only feature of the proceedings at all likely to attract the attention of a visitor was the fact that a motion made to reconsider was unanimously laid upon the table. This was followed by an outburst of applause, indicating the feeling of relief experienced by the members of the Association. The cordial hospitality and elaborate entertainment tendered to their guests by the profession and citizens of St. Louis contributed materially towards making this a most satisfactory and enjoyable session. Indications afforded at this meeting point to a hearty support by the profession of the International Medical Congress to be held in Washington in September, 1887.

The Association was entertained at grand concerts on Tuesday and Thursday evenings in the Exposition-Building, and at a reception and ball at the Merchants' Exchange on Wednesday evening by the profession and citizens of St. Louis. A number of private receptions were also given on Thursday in addition to the concert, and on Friday, after the adjournment of the Association, the visiting members were taken on a steamboat excursion fifteen miles along the city front on the Mississippi. In addition, numerous courtesies were accorded by the local profession, which were fully enjoyed and highly appreciated.

First Day's Proceedings. Tuesday.—The meeting was called to order by Dr. Le Grand Atwood, Chairman of the Committee on Arrangements, who introduced the President, William Brodie, M.D., of Detroit, Michigan.

The Chairman of the Committee also presented the programme for the meeting, which was adopted.

The President announced that the session would be formally opened by the Rev. Montgomery Schuyler, D.D., who then offered prayer.

Dr. Atwood next introduced Hon. D. R. Francis, Mayor of St. Louis, who extended a cordial welcome to the visiting members on the part of the municipal government and the citizens of St. Louis: to this city he gave the title of "the healthiest city in the United States." He briefly reviewed some of the evidences of recent progress in the healing art, and expatiated upon its future prospects and possibilities.

The address of welcome by the Chairman of the Committee on Arrangements was next delivered by Dr. Atwood, who also read a number of invitations to the Association.

Protests against the admission of delegates from the Philadelphia County Medical Society, New York Academy of Medicine, Davidson County (Tennessee) Medical Society, Mississippi Valley Medical Society, and the Tri-States Medical Society were read and referred to the Judicial Council. Dr. Deering J. Roberts entered a protest also against the admission of the representatives of the Tennessee State Medical Society, which took the same course as the preceding.

Drs. William N. Morrison, H. J. McKillops, of St. Louis, William H. Atkinson, of New York, and O. Manfred Johnson, of Harvard, Illinois, were made members by invitation.

Dr. Samuel Logan, of New Orleans, First Vice-President, took the chair, and Dr. William Brodie delivered the

PRESIDENT'S ADDRESS.

After congratulating the members of the Association upon the continued interest in its meetings, and the evident appreciation of the opportunity it affords of renewing old friendships and of making new ones, he referred to the fact that during the past year three ex-Presidents of the Association—W. K. Bowling, M.D., of Tennessee, John L. Atlee, M.D., of Pennsylvania, and Austin Flint, M.D., of New York—had died. He paid a fitting tribute of respect to the memories of these eminent members of the profession, and, after briefly sketching their lives, he expressed the hope that those who follow might fittingly succeed them. He then reviewed the history of the organization since 1846, and stated that its primary purpose was to elevate the tone of the profession and the standard of the medical colleges and of medical education, in which it had been quite successful.

Only four of the original members of the Society are alive to-day,—Dr. N. S. Davis, A. Stillé, Alonzo Clark, and P. L. Bush, the first two having subsequently served the Associa-

tion as presiding officer. He denounced those medical journals which persistently misrepresent the Association. The official organ of the Society, the *Association Journal*, is now in a flourishing condition. He recommended that two new Sections shall be formed, one on Medical Jurisprudence, and one on Dermatology and Syphilis. He warned the members against assuming the responsibility of prescribing patent or secret remedies, or giving testimonials for them.

No benefit, he believed, would accrue from modelling the Association upon the plan of the British Medical Association, the present plan having all of its advantages without any of its disadvantages. In conclusion he reviewed the work which had been already done for the International Congress, and invited the co-operation of all present in making it a success.

A vote of thanks was tendered to the President on motion of Dr. Murphy, of Minnesota.

A memorial from the Women's Christian Temperance Union was referred to the Section on State Medicine for discussion.

Dr. J. S. Lynch, of Baltimore, read the report of the Committee on Preliminary Arrangements for the International Medical Congress, in which it was stated that the duty assigned to the committee had been performed, and that the affairs of the Congress were now in the hands of an Executive Committee. The report was on motion adopted. A motion to reconsider was made, and by unanimous vote was laid upon the table.

The Amendment to the Constitution offered at the last meeting, authorizing the Sections to nominate their own officers, was adopted after discussion. The Secretary announced the reception of a number of papers not on the programme. On motion, they were referred to the appropriate Sections.

The Association then adjourned to allow the members to select their representatives on the Nominating Committee.

Second Day, Wednesday.—The session was opened at ten o'clock, the First Vice-President in the chair.

The Secretary announced the following committee upon the President's Address: Drs. Murphy, of Minnesota; Garcelon, of Maine; and Gihon, of the United States Navy.

Dr. Nicholas Senn, of Milwaukee, read his annual address as Chairman of the Section of Surgery and Anatomy.

ADDRESS ON SURGERY.

The frequency with which grave complications followed even the most trivial operations before the introduction of the modern treatment of wounds induced the great Hunter to remark, "The necessity for operation is in truth the defect of surgery." To-day, with an improved technique and the means at our disposal which, if properly applied, will furnish almost absolute protection against

wound-infection, the surgeon can, with a just source of pride and gratification, confirm the correctness of the assertion made centuries ago by Celsus, "*Qua manu potissimum curat.*"

Reviewing the status of surgery, and its recent progressive and aggressive manifestations, he declared that operations which a few years ago would have been deemed impossible or unjustifiable have become established legitimate surgical procedures. In obscure, doubtful cases the scalpel is now frequently resorted to, without fear of causing additional complications, for the purpose of making *intra vitam* an anatomical diagnosis. Modern surgery has achieved its greatest triumphs in enlarging the field for the direct local treatment of disease, thus enabling the surgeon to treat with success injuries and lesions beyond the reach of medicinal agents. In the field of abdominal surgery this is most evident. Experimental research and clinical experience have demonstrated that organs and parts of organs which were heretofore regarded as indispensable and essential can be successfully extirpated when they are the seat of injury and disease. The title selected for the address is, "The Present Status of Abdominal Surgery."

A condensed brief account of the more recent advances made in the surgical treatment of injuries and diseases of the abdominal organs interests equally the physician and surgeon. Without trespassing upon the field of the ovariologist and gynecologist, he confined his consideration to such lesions of the abdominal organs as present themselves to the physician and general surgeon. It is the especial aim to point out the limitation of abdominal operations and to draw a distinct line between the feasibility and justifiability of such operations.

1. Penetrating Wounds of the Abdomen.—

The recent papers by Dr. Dennis and Dr. Bryant, published during the past year, were mentioned as indicating the deep interest which has been awakened among American surgeons on this practical and important subject. Dennis has well said, "It is a source of national pride that laparotomy in penetrating wounds and visceral injuries of the abdomen was conceived, developed, and perfected in America."

The necessity of making a diagnosis between penetrating and visceral injury was primarily insisted upon. A distinction between punctured and gunshot wounds of the abdomen is also important from the point of view of a diagnosis and treatment. The former have been shown by statistics to be less likely to be complicated by visceral injury than bullet-wounds, and consequently afford a better prognosis, and do not call so uniformly for treatment by abdominal section. Owing to the frequency of recoveries after stab-wounds without operation, the thoughtful surgeon

must hesitate unless the symptoms are such that the existence of visceral injury can be assumed with a reasonable degree of certainty. In gunshot wounds laparotomy is generally necessary. The brilliant results which have been obtained by Bull, Hamilton, and others in desperate cases of multiple perforations of intestines by operative treatment, afford abundant encouragement for imitation of their practice. The methods advocated are, preventing infection by covering the wound with an antiseptic compress until preparations can be made for more effective treatment, early abdominal section in an aseptic atmosphere (corrosive sublimate in preference to carbolic acid), temperature of room 80° to 90° (F.). Operation has for its objects:

(1) Positive diagnosis; (2) arrest of hemorrhage; (3) restoration of continuity; and (4) removal of extravasation. Exploration by the finger or a probe is never justifiable. After making the incision, hemorrhage should be controlled by ligature. Enterectomy, if necessary, leads to the use of the Gerny Lembert suture for approximation of divided ends of the bowel. Irrigation of peritoneal cavity and sponging with a weak solution of corrosive sublimate should be carefully done, and the toilet of the peritoneum strictly attended to. If any doubt remain of the aseptic condition of the abdomen, drainage is indicated. After-treatment of the patient is of acknowledged importance.

II. *Laparo-Colotomy*.—In cases of rectal cancer not amenable to extirpation, Madelung advises that the colon should be divided across low down, and the peripheral end should be permanently closed by inverting the margins deeply and applying two rows of sutures. A preternatural anus is established by stitching the proximal end to the margins of the wound in the same manner as in forming an intestinal fistula in any other locality. The advantages of this method were briefly advocated.

III. *Subcutaneous Laceration of Intestines*.—Subcutaneous traumatic rupture constitutes one of the darkest chapters of abdominal surgery. Berger insists that laparotomy should be performed in all cases where a diagnosis of intestinal rupture can be made. According to a recent paper by Weir, collapse, rapid respiration, frequent wiry pulse, vomiting, thoracic respiration, emphysema, and absence of hepatic dullness are among the most important symptoms for establishing a probable diagnosis.

After laparotomy, circular resection and suturing of the bowel should be practised in preference to the advice given by Chavasse, Berger, and Verneuil of establishing an intestinal fistula.

IV. *Intestinal Obstruction*.—Schwann has collected one hundred and ninety cases of intestinal strangulation treated by laparotomy, including three cases observed by himself in

the practice of Mikulicz. He refers to difficulties of diagnosis, and pleads for early interference. Of this number 64.2 per cent. died, the mortality before the antiseptic treatment being 73 per cent., and since that time 58 per cent.

The cause of the large mortality is the want of appreciation by the physician of the importance of early resort to operative measures. The following causes were then considered: 1, intussusception; 2, enterolithiasis; 3, entero-stenosis; 4, strangulation, including under this term volvulus, torsion, internal hernia, and incarceration by bands of cicatricial tissue. The following rules were laid down by J. Grey Smith for treating intestinal obstruction by abdominal section:

"1. Make the incision in the abdominal line below the umbilicus.

"2. Fix upon the most dilated or most congested part of the bowel that lies near the surface, and follow it with the finger as a guide to the seat of obstruction.

"3. If this fail, draw the intestine out of the wound, carefully covering it, until increase of distention, or congestion, or both, in one of the coils give an indication that the stricture lies near.

"4. If there be considerable distention of the intestines, evacuate their contents by incision, and suture the wound. Never consider an operation for intestinal obstruction inside the abdomen finished until the bowels are relieved from over-distention.

"5. Be expeditious; for such cases suffer seriously from shock. The whole operation ought to be concluded in half an hour."

V. *Enterectomy*.—The experience of Billroth corroborated the opinion, now generally accepted, that primary typical enterectomy and enterorrhaphy should not be performed in cases of strangulated hernia and internal strangulation.

The successful case of Weir of resection of the large intestine for malignant disease was referred to, and his statistics of thirty-five cases analyzed. The propriety of excision of the colon for malignant disease cannot be questioned, and if it be found that the diseased mass cannot be removed an artificial anus can be established at once, with or without excision, which will at least remove the symptoms due to obstruction.

VI. *Rupture of Diaphragm*.—Such cases are so uniformly fatal under the expectant plan that operation would be certainly justifiable.

VII. *Treatment of Peritonitis by Abdominal Section and Drainage*.—The expedient was discussed and recommended in connection with perforative peritonitis, tubercular peritonitis, chronic peritonitis with effusion and ascites.

VIII. *Gastrotomy*.—After reviewing the usual conditions calling for gastrotomy, he referred to Alsberg's collection of one hun-

dred and seven cases in which gastric fistula had been made for various conditions: extraction of foreign bodies, malignant disease of oesophagus, non-malignant stricture of oesophagus, and cicatricial stenosis of the pylorus.

IX. *Pylorectomy.*—Billroth's operation has been performed sufficiently often for pyloric cancer to allow deductions to be drawn as to its justifiability. The operation will be useful in proportion to the early date of the positive diagnosis. Ulcer of stomach is a condition for which pylorectomy has been performed with reasonable success. Of ten cases reported by Kramer four cases recovered; a second operation being required in one in less than a year after the excision.

X. *Gastro-Enterostomy.*—This operation was devised by Wöelfer as a substitute for pylorectomy in that class of cases in which, after an exploratory incision, it is found impossible to extirpate the diseased pylorus.

The objection is that the pathological condition is left unchanged.

XI. *Duodenostomy.*—Langenbeck, in 1880, devised this operation for the purpose of establishing a permanent fistula in order to introduce food in which the general condition of the patient precludes the more grave operation of pylorectomy.

XII. *Jejunostomy.*—The results of this expedient, planned and executed by Pearce Gould, and similar to the preceding, have been so unsatisfactory that future attempts in the same direction should be abandoned as incompatible with the true aim and advancement of abdominal surgery.

XIII. *Splenectomy.*—The numerous extirpations of the spleen made by Zesas upon animals have demonstrated that it is not an essential organ, and that its physiological function in the production of blood-corpuscles is adequately performed by vicarious organs, so that we can safely include splenectomy for visceral injuries and local diseases of the spleen among the well-established legitimate surgical procedures.

XIV. *Surgery of the Gall-bladder.*—Cholecystotomy, cholecystectomy, and duodenocholecystotomy were referred to as still theoretical operations, but promising usefulness.

XV. *Injuries and Surgical Affections of the Liver.*—Wounds, abscess, and echinococcus cysts were considered. Where the cyst develops upon the upper surface of the liver, the expedient of opening the chest, as has been done by Israel and Volkmann, commends itself as the safest and most expedient operation.

XVI. *Surgery of the Pancreas.*—The surgery of the pancreas belongs to the future. The physiology of the organ and the symptomatology of the diseases of the organ will lead to the limitations within which excision will be justifiable.

XVII. *Laparo Nephrectomy.*—This operation has a legitimate sphere in cases of large

tumors of the kidney which cannot be removed through a lumbar incision. The operation also permits an examination of the opposite kidney, a decided advantage. Huguot extirpated successfully a retro-peritoneal sarcoma which was intimately connected with the kidney in a girl 6 years of age. In this case the renal artery and vein were tied separately. Whenever practicable, the integrity of the peritoneal cavity should be restored by suturing, and, if required, drainage established in the lumbar region.

XVIII. *Laparo-Nephrotomy.*—This operation is indicated in all cases by hydronephrosis and pyonephrosis, in which, owing to attendant circumstances, the lumbar operation cannot be performed; also where a positive diagnosis cannot be made as to the locality and nature of the tumor, and also where there is disease of the opposite kidney, or great general debility of the patient.

XIX. *Tumors of Omentum Majus.*—Primary malignant disease of the omentum, if it could be recognized early, would offer most favorable conditions for successful radical extirpation by abdominal section. Cystic tumors and echinococcus cysts are most favorably located for successful treatment by abdominal section and drainage.

XX. *Tumors of Mesentery.*

XXI. *Retroperitoneal Tumors.*

In conclusion, he reminded the members of the progress made in abdominal surgery in this country, and of the many valuable contributions made to the subject by American surgeons, and called upon them to prize it for the honor of American surgery.

Dr. S. C. Gordon, of Portland, Maine, read the Annual Address of the Chairman of the Section on Obstetrics and Diseases of Women.

ADDRESS ON OBSTETRICS, ETC.

The first subject considered was the duty of the accoucheur after exposure to septic influences. The paper of Dr. George F. French was referred to, and his conclusions endorsed that strict antiseptic methods, if adopted, will enable the accoucheur to resume his work without danger to his patients.

The diagnosis of early pregnancy was next discussed, and Hegar's sign—of increase in the anterior curvature of the uterus, with increased elasticity of the walls—mentioned approvingly. For obstinate vomiting of pregnancy he advised forcible dilatation of the cervical canal below the internal os and lifting the uterus out of the pelvis and supporting by cotton packs or some form of pessary. This will obviate the necessity of resorting to abortion for this very distressing symptom in a great many cases.

The induction of premature labor in cases of contracted pelvis, by introducing a bougie, was declared a useful expedient.

The treatment of parturient women was then considered, and anæsthetics in labor

recommended. The forcible removal of the secundines was deprecated.

Passing to gynæcology, he devoted the rest of the address to the operation of removal of the uterine appendages, familiarly characterized as Battey's, Tait's, and Hegar's operations. Diseases of the uterus and pelvic region are often the hidden causes of symptoms interpreted as "hysteria," a diagnosis which he condemned as doing great injustice to suffering women.

He concluded—

1. That these so-called hysterical symptoms occur almost exclusively in women. That whenever any of them do occur in men they are much less in degree, even if they do not differ in kind.

2. That it is fair to presume, from the first proposition, that it is due to disease of some organ or organs peculiar to women.

3. That they are not due to disease of the uterus alone, for when all apparent abnormalities of the uterus are corrected the symptoms very often are not in the least relieved.

4. That all modes of treatment other than operation have failed to cure, and, in most instances, have not ameliorated the symptoms, even where the disease was believed to exist in the uterine appendages.

5. That the large majority of all the cases operated upon have been entirely cured of the symptoms for which the operation was made, and the remnant have been relieved and are continuing to improve.

6. That it is impossible in a majority of cases to determine by the touch diseases of these organs that will produce the symptoms alluded to.

7. That one can by these symptoms alone make a sufficiently satisfactory diagnosis to warrant the operation.

8. That if, after correction of all well-known and clearly-diagnosed uterine troubles, these symptoms are not relieved, we are required for the cure of our patient to recommend the remedy.

9. That the operation does not in any case destroy the sexual desire, or in any way unsex the woman, except in so far as it may prevent further child-bearing.

10. That in a large majority of cases requiring the operation the woman is already sterile.

11. That in his own experience the specimens removed have been found so changed by inflammatory action as to be cirrhotic or otherwise destroyed either by softening or cystic degeneration of both ovaries and tubes, with very frequent stenosis of the latter.

12. That a fatal result from the operation is extremely rare, if it be carefully performed and closely and intelligently managed as to the after-treatment. Out of twenty-five cases operated upon there was but one death.

The papers were referred to the appropriate Sections for discussion.

Dr. A. L. Gihon, Chairman of the Rush Monument Committee, presented the following report, which was adopted:

"To the President and Members of the American Medical Association."

"Your Committee begs leave to report that in obedience to your resolutions on the 30th April, 1885, at the thirty-sixth annual meeting of the Association at New Orleans, Louisiana, the Rush Monument Committee has been instituted by the appointment of one member from each of the States, Territories, and national services represented in the Association; and the Standing Committee thus organized will forthwith proceed upon the duty intrusted to it by the Association, to wit, the collection of funds, etc., for the erection of a statue to Dr. Benjamin Rush, in the city of Washington, by the members of the profession of medicine in the United States.

"Your Committee appointed at Washington in 1884 by the lamented Dr. Austin Flint, in its report presented at New Orleans, enumerated the monuments which have already been erected at the National Capital in commemoration of the men who have contributed to the national renown, and stated that appropriations had also been made by Congress for statues to Lafayette and Garfield. Since that report, and doubtless in consequence of it, various public bodies have proposed similar memorials to their great leaders. The Church, already represented in the person of Martin Luther, is to have its statue to Wesley. The deaf-mutes have taken action towards the erection of a monument on their beautiful Kendal Green to their eminent teacher Gallaudet. Philanthropy is to have its marble effigy of Peabody; and the intrepid explorers, who have lifted the curtains of dense jungle and rugged mountain upon new lands, are to be personated in him who, greatest of them all, led the way to this new world; while Grant and McClellan, Hancock and Shields, McDonough and Barry, are to be added to the already long array of Presidents and military and naval heroes.

"With statesmen, rulers, soldiers, and sailors, the scientist and the philanthropist, the discoverer and the teacher, the jurist and the divine, all given prominence among the adornments of this beautiful capital city, no further time should be lost by the medical profession in completing its enduring testimonial of one who was not only a great physician and teacher of medicine, philosopher, philanthropist, and accomplished writer, but a fearless patriot and founder of the Republic, a signer of the Declaration of Independence, an officer of the army of the Revolution, and one of the authors of that Federal Constitution under which we now happily live.

"With this announcement, the Rush Monument Committee will at once undertake the work of obtaining subscriptions, which have

been limited by resolution of the Association to one dollar from each member of the profession of medicine in the United States, and receiving such voluntary donations as may be made by persons interested in this great undertaking.

"All which is respectfully submitted.

"For the committee, Albert L. Gihon, M.D., Chairman; George H. Rohé, M.D., Secretary; J. M. Toner, M.D., Treasurer."

"I am directed by the Rush Monument Committee to report to the Association the election of Dr. George H. Rohé, of Maryland, to be Secretary, and of Dr. Joseph M. Toner, of the District of Columbia, to be Treasurer.

"In accordance with the instituting resolutions, the following members resident in or near Washington constitute with the Chairman an Executive Committee, viz.,—Albert L. Gihon, U.S. Navy, Chairman; George H. Rohé, Baltimore, Maryland; Joseph M. Toner, Washington, D.C.; Henry H. Smith, Philadelphia, Pennsylvania; Charles Smart, U.S.A., Washington, D.C.; Preston H. Bailhache, U.S.M.H.S., Baltimore, Maryland; Samuel J. Jones, Chicago, Illinois.

"I am also directed to report that the Committee has adopted rules for the collection and responsible expenditure of the funds collected for the purpose of the monument, and has determined upon Riggs Bank at Washington as the depository of said funds.

"Respectfully submitted,

"ALBERT L. GIHON,

"Chairman."

Third Day.—Session opened by prayer.

The Committee on Arrangements announced some additional invitations.

The Committee on Nominations reported as follows:

The following States were represented: Alabama, —; Arkansas, P. O. Hooper; California, —; Colorado, J. W. Graham; Connecticut, J. C. Wile; District of Columbia, J. W. Bulkely; Delaware, —; Florida, T. O. Summers; Georgia, J. W. Bailey; Illinois, J. E. Owens; Indiana, J. B. Harvey; Iowa, W. Watson; Kansas, C. B. Mottram; Kentucky, W. H. Wathen; Louisiana, Joseph Jones; Maine, Charles E. Webster; Massachusetts, E. W. Cushing; Maryland, George H. Rohé; Michigan, H. O. Walker; Mississippi, P. W. Rowland; Missouri, J. F. Dudley; Minnesota, H. H. Kimball; Nebraska, W. M. Knapp; New Hampshire, —; New Jersey, E. L. B. Godfrey; New Mexico, W. R. Tipton; New York, E. S. F. Arnold; North Carolina, C. J. O. Hagan; Ohio, H. J. Sharp; Oregon, —; Pennsylvania, C. J. Lange; Rhode Island, H. R. Storer; South Carolina, R. A. Kinloch; Tennessee, Duncan Eve; Texas, J. F. Y. Payne; Vermont, A. E. Woodward; Virginia, G. B. McCorkle; West Virginia, G. W. Baird; Wisconsin, W. T. Gallaway; United States

Army, Ely McClellan; United States Navy, J. C. Speir; United States Marine Hospital Service, W. H. Wyman.

They have the honor to report the following:

For President, Dr. E. H. Gregory, of St. Louis, Missouri.

First Vice-President, Dr. E. H. Miller, of Stillwater, Michigan.

Second Vice-President, Dr. W. B. Welch, of Arkansas.

Third Vice-President, Dr. William H. Pancoast, of Philadelphia, Pennsylvania.

Fourth Vice-President, Dr. William C. Wile, of Connecticut.

Permanent Secretary, Dr. William B. Atkinson, of Philadelphia.

Assistant Secretary, Dr. J. Nevins Hyde, of Chicago.

Treasurer, Dr. R. J. Dunglison, of Philadelphia.

Librarian, Dr. C. H. A. Kleinschmidt, of Washington, D.C.

Committee on Necrology: J. M. Toner, Washington, D.C.; Alabama, Jerome Cochran; Arkansas, C. Watkins; California, Beverly Cole; Colorado, I. H. Hawkins; Connecticut, F. H. Whittemore; District of Columbia, C. H. A. Kleinschmidt; Delaware, L. P. Bush; Florida, R. B. Burrows; Georgia, R. Battey; Illinois, S. H. Montgomery; Indiana, J. F. Hibbard; Iowa, J. Williamson; Kansas, C. V. Mottram; Kentucky, R. M. Farleigh; Louisiana, J. W. Duprés; Maine, A. J. Fuller; Massachusetts, M. G. Parker; Maryland, T. B. Evans; Michigan, H. H. French; Mississippi, B. F. Kittrell; Missouri, L. Bremer; Minnesota, W. W. Mayo; Nebraska, E. M. Whitten; New Hampshire, J. J. Berry; New Jersey, J. N. Quinby; New York, John Shradly; North Carolina, Eugene Grissom; Ohio, J. F. Baldwin; Oregon, —; Pennsylvania, D. G. Brinton; Rhode Island, C. W. Parsons; South Carolina, R. A. Kinloch; Tennessee, J. Y. Crawford; Texas, J. W. McLaughlin; Vermont, E. F. Upham; Virginia, George B. McCorkle; West Virginia, J. H. Pipes; Wisconsin, S. S. Ridell; United States Navy, J. C. Speir; United States Army, M. K. Taylor; U.S.M.H.S., H. S. Austin; Dakota, Dr. Van Velsor; New Mexico, G. W. Hanson.

Committee on State Medicine: Alabama, G. A. Kitchen; Arkansas, J. A. Dibbrell, Jr.; California, F. H. Terrill; Colorado, P. R. Thoms; Connecticut, George B. Porter; District of Columbia, J. D. Patterson; Delaware, —; Ogle; Florida, E. T. Sabal; Georgia, J. A. McGaston; Illinois, J. H. Hollister; Indiana, J. H. Beasley; Iowa, P. W. Llewellyn; Kansas, S. Schenck; Kentucky, William Bailey; Louisiana, C. W. Day; Maine, M. C. Ledwood; Maryland, John Morris; Massachusetts, Ira Russell; Michigan, H. F. Baker; Minnesota, W. A. Stenckfield; Missouri, J. M. Allen; Mississippi, M. S. Craft; Nebraska,

A. R. Mitchell; New Hampshire, G. P. Bonn; New Jersey, E. L. B. Godfrey; New York, E. S. F. Arnold; North Carolina, C. J. O. Hagan; Ohio, H. J. Sharp; Oregon, ———; Pennsylvania, W. Snively; Rhode Island, W. T. Parker; South Carolina, C. Kolbrook; Tennessee, J. B. Bowling; Texas, C. H. Wilkinson; Vermont, H. D. Holton; Virginia, J. E. Chancellor; West Virginia, S. D. Wilson; Wisconsin, C. Alexander; U.S.N., A. L. Gihon; U.S.A., E. McClellan; U.S.M.H.S., W. H. Long; Dakota, — Van Velsor; New Mexico, W. R. Tipton.

Members of Judicial Council: N. S. Davis, Illinois; R. C. Moore, Nebraska; H. Brown, Kentucky; T. A. Foster, Maine; William Brodie, Michigan; James A. Gray, Virginia; D. J. Roberts, Tennessee.

Trustees of Journal of the American Medical Association: P. O. Hooper, Arkansas; A. Garcelon, Maine; L. S. McMurtry, Kentucky.

Place of next meeting: Chicago, Illinois, on the first Tuesday in June, 1887.

Chairman of Committee of Arrangements: Charles Gilman Smith, of Chicago, Illinois.

All of which is respectfully submitted.

P. O. HOOPER, *Chairman*.

WILLIAM C. WILE, *Secretary*.

The following Chairmen and Secretaries of Sections were nominated yesterday:

Medicine, John L. Lynch, Baltimore; J. B. Marvin, Louisville, Kentucky.

Gynaecology, F. M. Johnson, Kansas City; W. W. Jaggard, Chicago.

Surgery, Henry H. Mudd, St. Louis; John B. Roberts, Philadelphia.

Ophthalmology and Otology, W. H. Scott, Cleveland, Ohio; J. H. Thompson, Kansas City.

Diseases of Children, De Laskie Miller, Illinois; W. B. Lawrence, Batesville, Arkansas.

Oral and Dental Surgery, J. S. Marshall, Chicago; E. S. Talbot, Chicago.

State Medicine, George H. Rohé, Baltimore; W. H. Wyman, U.S.M.H., New York.

The Committee on President's Address reported through Dr. A. L. Gihon, Chairman:

"1. That in their opinion it is proper and desirable that this Association shall without delay memorialize Congress in behalf of the pending resolution to appoint a scientific commission of three members of the profession of medicine to visit the habitat of yellow fever in Cuba, Mexico, and Brazil with a view to determine the validity of the claims of Drs. Carmona and Freire to have discovered a means of preventing and modifying attacks of that disease.

"2. That your Committee are not agreed among themselves as to the suggested recession from the recommendation of the use of the metric system in medicine.

"3. That they heartily approve of the suggestion of the President that the Association,

having created a Section of Medical Jurisprudence, shall further establish a Section on Dermatology and Syphilis.

"4. That they concur with the President as to the wisdom of the provision that the several Sections shall elect their own officers from among the men of recognized authority and experience in the special work of such Sections; and they are further of the opinion that the efficiency of these Sections will be enhanced by the continuance in office from year to year of the Secretaries of said Sections.

"5. That they endorse the views of the President respecting the Journal of the Association and exclusive proprietary interest of this Association in the papers and reports which are made parts of its Transactions.

"6. That the Association should emphatically denounce the endorsement by certificate, advertisement, testimonial, or indirect approval in any form, of proprietary remedies and appliances, and should instruct the Judicial Council to take action in all such cases without formal presentation of charges; that, in the words of the President, 'The stigma of professional disgrace shall rest upon any regularly educated physician who allows his name to be advertised as the endorser of any patent, secret, or proprietary medicine.'

"7. That it is desirable that the Association shall appoint a committee at this meeting to consider the advisability of amending the organic law of the Association by the establishment of branches, or in whatever other way may be deemed best, and to report thereon at the next annual meeting of the Association.

"8. That they earnestly echo the wish of the President that the members of the profession will cordially co-operate in the effort to make the American session of the International Medical Congress creditable to the country, and attractive and instructive to the foreign members, sacrificing their personal and private piques and disappointments in generous emulation to contribute to that success which had been unconditionally pledged in the invitation tendered the foreign members of the Congress to meet in the United States.

"All of which is respectfully submitted.

(Signed) "JOHN H. MURPHY, Minnesota.
"ALBERT L. GIHON, U. S. Navy.

"ALONZO GARCELON, Maine.
"Committee."

After considerable discussion, and on a call for the previous question, the report was adopted as read, by an overwhelming vote.

Dr. N. S. Davis, of Chicago, Chairman of the Standing Committee on Meteorological Conditions and their Relations to the Prevalence of Diseases, also concerning the Subject of Collective Investigation of Disease in Co-operation with the Committee of the British Medical Association, reported progress.

The committee was continued and the report adopted.

J. M. Keller, of Arkansas, read a report of the Special Committee on Cremation. The subject had been annually before the Association for years, and the committee believed that the time had come when the Association should put itself upon record in condemnation of earth-burial and in favor of cremation.

The report, on a call for the previous question, was adopted. On motion of Dr. Thad. A. Reamy, of Cincinnati, the action was reconsidered, on account of some expressions in the report which were erroneous in form and substance, and too strong in condemning the prevailing method of Christian burial. On motion of Dr. John Morris, the report was then referred to the Section on State Medicine for consideration and final report to-morrow.

A motion offered by Dr. John B. Roberts, of Philadelphia, directing the Secretary of the Association to explain why he had not presented the decision of the Judicial Council in regard to the protest against the admission of the delegates from the Philadelphia County Medical Society, was decided out of order by the President, as the papers were still in the hands of the Judicial Council. An appeal against the decision of the chair taken by Dr. Roberts was not sustained.

Dr. James T. Whittaker, of Cincinnati, Ohio, the Chairman of the Section on the Practice of Medicine, then read his address, taking for his subject

SOME POINTS IN BACTERIOLOGY.

Investigations into the cause of disease represent the third or most developed stage of medicine, having been preceded by the stages of clinical observation and of pathological anatomy.

The etiology of acute infections is comprised under the single term "Bacteriology," the bacterium having come in the course of time to include all pathogenic as well as many innocent micro-organisms. That specific differences exist between different bacteria must be admitted at the outset, while deviations of form and function within certain limits may occur, such as have been observed in floriculture. It is the germ and not the form that is essential. The morphology of bacteria is not simply a question of size and shape, but includes motion, color, affinities for color, and manner of growth.

The different forms of bacteria,—micrococci, bacilli, and spirilla,—their growth into zoöglæa, the question of culture-soils, temperature necessary, need of oxygen, were next considered. The existence of spores, and the division of bacteria according to De Bary into arthrospores and endospores (the pathogenic bacteria belonging to the latter group), and the mode of invasion and dissemination

in the tissues of the body, were reviewed, and the statement made that no germs exist in healthy blood, although the intestinal canal contains them (saprophytes) in abundance.

Among diseases produced by germs, erysipelas stands prominent; it is a surface-disease, open to inspection, and has been carefully investigated by Fehleisen and others. Another good illustration of the entrance of a pathogenic bacillus into the organism is seen in diphtheria, in which the dumb-bell bacillus produces deep and extensive layers of false membrane in the fauces, pharynx, and trachea. The glutinous and pulaceous mass thus formed is a quicksand to catch and entangle myriads of micro-organisms. This exists in several layers, the deepest being formed of a fibrogenous exudation which escapes from the blood-vessels and opposes a barrier to the further advance of the bacilli. Breaks in this barrier permit the absorption of the virus emanating from the bacteria or their products to produce the constitutional symptoms of the disease. The invasion of the tissues by the tubercle-bacillus and the formation of the giant-cell were briefly discussed, and the destruction of bacilli by leucocytes referred to. Pathogenic micro-organisms produce the phenomena of disease principally by inducing a toxæmia with virulent products similar to ptomaines.

These investigations indicate the direction of research at present, and also the line of study by which we shall be able to combat the cause of infectious disease in a direct way by specific indication. They show us that inflammation is not the cause, but the effect, of disease which is caused by infection, and show us the direct road to cure through comprehension of the nature of infection.

ENTERTAINMENT FUND, INTERNATIONAL MEDICAL CONGRESS.

Dr. A. Y. P. Garnett, of Washington, offered the following:

"*Resolved*, That the members of this Association are requested, upon their return home, to adopt such measures as may seem to them best adapted to call the attention of their respective members of Congress to the necessity of making an appropriation to assist the medical profession in properly receiving and entertaining the International Medical Congress in 1887."

This was unanimously adopted.

Dr. John H. Rauch read his address as Chairman of the Section on State Medicine.

STATE MEDICINE.

The definitions of Dunglison, Parkes, and De Chaumont of State Medicine were quoted without full endorsement. It is coming to be recognized that a distinction between preventive medicine—the field of the sanitarian—and curative medicine—the field of the physician—is artificial and unnecessary; and

in this view Richardson, in a recent address, takes a similar position. He says, "It is not a science, it is not even an art separated necessarily or properly from so-called curative medicine. On the contrary, the study of prevention and cure proceed well together, and he is the most perfect sanitarian, and he is the most accomplished and useful physician, who knows most both of the prevention of disease and of the nature and treatment of disease,—he who knows, in fact, the before and the after of each striking phenomenon of disease that is presented for his observation." Quotations from the publications of the Illinois State Board of Health, illustrating its doctrines and doings, were then given.

State Medicine may, therefore, be now defined as the *connection of the State with that branch of science which relates to the prevention, cure, or alleviation of the diseases of the human body*. It is only logical to consider under this subject the regulation of medical practice and medical education. The regulation of medical practice comes under the police authority of the State.

A marked improvement has been noticed in the last decade in the quality of instruction and length of terms in medical colleges, and in a great reduction in the number of bogus schools and diploma-mills.

The following conclusions were submitted:

1. That the best interests of the public welfare demand the highest attainable standard of educational qualification, skill, and ability—as well as of professional and personal honor, integrity, and morality—among those engaged in the practice of medicine.

2. That it is the duty of the State to exercise the inherent plenary power and authority which it possesses for the protection and promotion of the public welfare, to secure such standard.

3. That uniform State laws, exacting of every one aspiring to practise medicine proof of personal fitness and professional competency, would prove the most potent agency in improving the standard of medical education and in enhancing the dignity and usefulness of the medical profession.

Specifically, he wished to suggest that the American Medical Association should put itself upon record at this session as recommending the extension of the period of study to four years and of the attendance upon lectures to three full terms, with ample hospital practice and clinical instruction as the requirements for graduation in medicine. That the Committee on State Medicine be instructed to frame a law for the regulation of the practice of medicine, which law when endorsed by the Association shall be the standard with which all existing legislation on this subject should be made to conform as speedily as practicable, and which shall be urged for adoption by those States where no such law now exists.

The second part of the address was devoted to advances and discoveries in preventive medicine.

Whether by the rehabilitation of the National Board of Health or by the creation of a new organization, it is the imperative duty of Congress to complete the health defences of the country. The work of the American Public Health Association was referred to approvingly.

After an inspection of the quarantine maintained upon the Atlantic and Gulf coasts from the St. Lawrence to the Rio Grande, he is more than ever convinced that Asiatic cholera as well as smallpox and yellow fever may be effectually excluded from the United States by an intelligent use of the agencies still at our command.

The necessity of central control by the United States Government of immigrants was earnestly considered, and the able address concluded with a consideration of the bacterian origin of infectious diseases, and a renewed advocacy of general resort to vaccination as a sanitary necessity.

On motion, the addresses were referred to the Sections for further consideration.

MISCELLANEOUS BUSINESS.

Dr. R. J. Dunglison's report, as Treasurer of the Association, was then read. An increased amount of receipts of annual dues he attributed to the influence of the Journal. Balance on hand at end of year, \$378.29.

Dr. C. H. A. Kleinschmidt, the Librarian, reported the addition of 232 new titles to the Library, being twice as great as that of the preceding years.

Dr. A. L. Gihon offered the following amendment to the By-Laws:

"Resolved, That to the already existing Sections of this Association shall be added one to be known by the title of the 'Section on Dermatology and Syphilis.'"

This lies over until the next meeting.

He also offered a resolution, which was adopted, with regard to the recommendation contained in the President's address, that a committee be appointed to consider the subject of establishing branches of the Association, to report at the next meeting. The committee as subsequently appointed consists of Drs. Davis, Gihon, Toner, the President, ex-President, and four Vice-Presidents.

Friday, Fourth Day.—Session was opened by prayer by W. V. Tudor, D.D. Dr. Atwood, Chairman of the Committee of Arrangements, made a final report in reference to the river-excursion this afternoon.

General W. T. Sherman, being invited by the President to address the Association, made a few remarks congratulatory and courteous.

The Nominating Committee completed its work by nominating J. N. Quimby, of New Jersey, Chairman, and H. H. Kimble, of

Minnesota, Secretary, of the Section on Medical Jurisprudence.

The Committee on Publication and Trustees of the Journal presented their annual report through Dr. J. M. Toner.

The Journal had been issued regularly during the past year, the circulation having increased to 4271, including 3374 members of the Association. The financial condition was good. During the year a complete outfit of type had been purchased by the editor, and the Journal had been issued from its own office for the last year, thus effecting a saving of over seven hundred dollars per annum. At the solicitation of the Board of Trustees, Dr. N. S. Davis had consented to continue his valuable services as editor during the coming year.

The report was adopted with applause.

THE JUDICIAL COUNCIL REPORT.

As to the protest against the delegates from the Tri-States Medical Society, the Council stated that the Constitution of the American Medical Association could only recognize delegates from State and County Medical Societies, and representatives from a Tri-States Society could not be admitted. Protests were dismissed for want of sufficient evidence against the reception of delegates from the Davidson County Medical Society, Tennessee, Mississippi Valley Society, and Tennessee State Medical Society. With regard to the Philadelphia County Medical Society, "The Council, having reconsidered the question and heard evidence not forthcoming at the first hearing, came to the conclusion that, although the delegates held documents which usually entitle the holders to admission, the methods employed in their election were so irregular as to compel their rejection. The Council recommend the refunding of any dues paid by members, and refer the evidence back to the Philadelphia County Medical Society for adjudication."

The report was adopted.

Dr. Jackson, of Philadelphia, inquired as to the status of delegates from Philadelphia who had already registered.

The Chair decided that they had no status in the Association.

Dr. Roberts offered a resolution of investigation, whether or not the previous report of the Judicial Council had not been favorable to receiving the Philadelphia County Society delegates, and whether or not it had been presented the previous day to the Secretary of the Association in time to be read, and, if so, why it was not read.

The Chair declared Dr. Roberts out of order.

Dr. Eugene Smith, of Michigan, the Chairman of the Section, read a portion of his address on Ophthalmology, Otology, and Laryngology. Some of the principal points of interest in these several departments were rapidly sketched by the lecturer.

Dr. W. D. Haggard, of Tennessee, Chairman of the Section on Diseases of Children, read his address by title: "A Plea for the Better Recognition of the Importance of the Study of Diseases of Children."

Dr. John S. Marshall, Chairman of the Section on Dental and Oral Surgery, also by permission read his address by title. The preceding were all referred for publication.

The report on Necrology, as published from week to week in the Journal, was received and approved.

The Section on State Medicine reported the election of George H. Rohé, M.D., Baltimore, Maryland, Chairman, and W. W. Wyman, U.S.N., Secretary for the next meeting.

The Memorial of the Women's Christian Temperance Union, referred to the Section, was duly considered. The Section reaffirmed the resolutions passed by the Association at St. Paul and New Orleans, affirming that the use of alcohol had very deleterious effects on the human race, and recommending a course of study in hygiene with especial reference to this point in public schools, and welcoming any change in public sentiment in this direction. The drinking of alcohol is a cause of much physical and mental disease, and of a large proportion of the crime and pauperism of the country.

The resolutions offered by the Committee upon Cremation were considered by the Section, and the following adopted:

"Resolved, That a Committee of this Section be appointed to further consider the subject of cremation, with instructions to report their conclusions at the next meeting."

With regard to Dr. Rauch's suggestion, it was resolved that a committee be appointed to frame a law regulating the practice of medicine, to be presented at the next meeting for consideration.

The report of the Section on State Medicine was accepted.

On motion of Dr. Morris, it was resolved that the report of the Committee on Publication be received on the first day of the next session. Adopted.

Dr. John B. Roberts, of Pennsylvania, offered a resolution calling upon the President to state whether the report of the Judicial Council with reference to the protest against the Philadelphia County Medical Society was not presented on Wednesday, and if any effort was made to submit the report by the Secretary, and, if not, why not.

As the resolution contained reflections upon the action of the Judicial Council, it was, on motion of Dr. Ochterlony,

"Resolved, That the resolution be laid upon the table, and that all reference to the Judicial Council be expunged from it."

Dr. Roberts then offered his resignation as Secretary of the Section on Surgery and Anatomy, on the ground that the Philadelphia County Medical Society was denied rep-

resentation. This was accepted, and the Chairman of the Section directed to fill the vacancy.

Dr. Jackson, one of the Philadelphia delegation, submitted a protest signed by the disqualified delegates:

"We, the undersigned, regularly-accredited delegates of the Philadelphia County Medical Society to the American Medical Association, earnestly protest against the action of the Judicial Council by which one of the largest county medical societies in affiliation with the Association—one which has never violated its Code of Ethics or its laws—has been denied representation in the Thirty-Seventh Annual Meeting of the Association."

This was ordered to be entered upon the minutes.

The President appointed a number of delegates to foreign societies. The following delegates to the British Medical Association were appointed: N. S. Davis, Illinois; W. T. Briggs, Tennessee; Wm. H. Pancoast, Pennsylvania; S. C. Gordon, Maine; J. V. Shoemaker, Pennsylvania; E. Cutter, New York; E. Smith, Michigan; W. W. Dawson, Ohio; D. McLean, Michigan; B. A. Watson, New Jersey; Wm. Brodie, Michigan; L. H. Montgomery, Illinois; H. O. Walker, Michigan; and J. C. Cattell, of Ontario, Canada. Delegate to Canada Association, Wm. Brodie, of Detroit, Michigan.

Dr. Keller offered an amendment to the by-laws restoring the former method of electing officers of Sections.

Dr. H. M. F. Gaston, of Mobile, offered a preamble referring to the alleged discoveries of Carmona and Freire of the means of preventing yellow fever by inoculation, with the following resolution:

"Resolved, That the American Medical Association recommends prompt action by Congress in the appointment of a commission of experts to proceed to Brazil to investigate the claims made concerning protection against yellow fever by inoculation."

On motion of Dr. N. S. Davis, a vote of thanks was cordially tendered the Committee of Arrangements, the citizens of St. Louis, the railroads, and all who had contributed to the enjoyment of the members and the success of the meeting. Adopted by a standing vote.

Drs. Davis, McPheeters, and Johnson were appointed a committee to escort the President, Dr. H. E. Gregory, to the chair, who made a brief speech thanking the Association for the honor conferred.

The meeting then adjourned *sine die*.

THE SANITARY CONFERENCE OF THE STATE BOARD OF HEALTH, held on the 12th, 13th, and 14th instant, was a grand success. The proceedings were interesting and valuable, and are worthy of preservation in permanent form.

NOTES OF HOSPITAL PRACTICE.

PENNSYLVANIA HOSPITAL.

SERVICE OF J. M. DA COSTA, M.D.

MALARIAL ANÆMIA TREATED WITH ARSENIC AND IRON.

GENTLEMEN,—The man before you, William G., an Italian sailor, 50 years of age, was admitted December 17, suffering with malaria and anæmia. It was learned that he had been sick for a year with dyspepsia, weakness, and pain in his chest, and that this had been accompanied by marked loss of flesh.

When admitted, he was very weak; his face was pallid, his heart was contracting without much force; there was an anæmic murmur at the left base, and a venous hum in the vessels of the neck. His pulse was feeble, rapid, and compressible, and his spleen was enlarged.

Under treatment with Fowler's solution (five minims three times a day) and the pyrophosphate of iron (ten grains thrice daily) he gradually improved. His blood at first was thin and poor; when examined shortly after admission it contained only a million and a quarter red blood-corpuscles to the cubic millimetre; at the present time it contains over four million to the millimetre by actual count made yesterday. With this increase in the red blood-cells there has been a corresponding improvement in the man's general appearance and strength.

Arsenic is one of the best nerve-tonics that we possess; it is also one of the most trustworthy restorative agents for those states in which the blood is profoundly altered. Especially is this the case when some poison underlies the morbid condition, as malaria, for instance, or any other poison which affects the blood-making function. It is also of some service in ordinary anæmia, by increasing the number of the red blood-corpuscles and improving the quality of the blood.

The salt of iron which was employed in this case is one which has been thus far very little used. Some years ago, while making some experiments for the purpose of finding some simple salt of iron for hypodermic purposes, we finally settled upon this salt, made by precipitating iron from a solution of the citrate by the addition of a solution of pyrophosphate of

sodium. We had found it the least irritating solution for hypodermic use, and upon pushing our observations further we also found that it was extremely well borne by the stomach in doses of five or ten grains. It is not unpleasant to the taste, and may be given in water with simple syrup or with a little elixir of orange. It does not constipate, like other chalybeate preparations, or at least it is less constipating. The salt I refer to is very much the same as the now officinal pyrophosphate.

ACUTE RHEUMATIC ENDOCARDITIS TREATED WITH ALKALIES.

Our next case is one which is still acutely ill, occupying bed 37, Men's Medical Ward. He is 23 years of age, a laborer, colored. This is his history. Six years ago he had an attack of acute rheumatism which confined him to bed for eight weeks: therefore it must have been a severe attack. He then recovered health, and remained well until two weeks before admission, when he was again the subject of a rheumatic inflammation, this time in his knees; subsequently his shoulders and wrists were affected.

When admitted, on the 28th of December, his temperature was 100°, pulse 96; his tongue coated, bowels constipated, and his knees were swollen and painful. The urine was scanty, extremely acid, with an excess of urates, and a specific gravity of 1030, but without albumen. No heart-murmurs could be detected, as I find specially noted in the report of his examination upon admission and several times since then.

The patient was placed at once upon decided doses of the salicylates. On the first day he took ninety grains of salicylate of sodium, and this was continued for four days, when it was noted that he had no fever and no pain. The salicylate of sodium was then stopped and quinine given. Though he was very much better as regards his joint-symptoms, he now began to complain of pain and uneasiness about the heart. On the 8th of January a soft systolic murmur was heard at the apex. Coupling this with the statement that the heart had been examined daily since his admission into the hospital, you observe that it was only on the twelfth day after entering the ward (or the fourth week of illness) that now for the first time a systolic mitral murmur was perceived. He was

then taking twelve grains of quinine daily, which was at once stopped, as the salicylate had been a week before. He was then placed upon an ounce of bicarbonate of potassium daily, which he bore very well. Nevertheless the murmur in the heart persisted, although the man appeared otherwise quite well. He complained, however, of some pain and oppression, and the acute endocarditis developed affected more particularly the mitral valve.

On the 15th of January the murmur was still distinct, but cardiac uneasiness had disappeared. The potassium bicarbonate had been reduced on the 12th to half an ounce daily, which he has continued taking from that period to the present. The quinine was reduced to eight grains when the bicarbonate was commenced, and he is still taking this quantity.

His morning temperature is now 99°. You see on this sheet that from the time the endocarditis developed the temperature had many variations. It was 103°; even as late as the 20th of this month it was 103°: therefore it was a fever-temperature, irregular it is true, but continued, for only once during this time, on the 19th, did it drop to 99½°.

Proceeding to examine the patient, I find that he still has fever, but I can elicit no evidence of pain by pressure over the cardiac region, and shortness of breath no longer troubles him. His respirations are twenty-four in the minute, which, considering that he is in a state of agitation caused by having to come before you, cannot be called very much accelerated. He has an endocardial systolic murmur still evident at the apex, but it is not harsh. It is followed by a distinct second sound. The heart's impulse is marked, but there is no increased percussion-dulness in the cardiac region. Examining the back of the chest, I find the respiratory sounds are feeble, particularly over the left lung, and there is slight impairment of resonance at the left base corresponding with the area of feeble breathing. This is due to moderate congestion. He has no cough. His pulse is only 64 to the minute this morning, and it has some resistance to the touch. With reference to this pulse, I may as well tell you that throughout the disease his pulse has been rather slow; the records say 54, 66, 62, 64, 58, 65, 60, and 56. It is true that it jumped to 90 once; but it was only a temporary affair, for in

the evening it was down to 80, and on the next day it had returned to 60 per minute.

Therefore, notwithstanding the inflammation of the heart which here coexisted, the action of the organ has been slower than in health; and this appears more marked because the man has had no pericardial effusion or anything else to interfere with the movements of the heart.

Some remarks are suggested by this case, first, upon the cause of the disorder, and, secondly, upon the question of treatment.

First, as to the etiology of the case, I will point out that this man went through a severe attack of rheumatism years ago, but without presenting symptoms of heart-disorder, because he gave no evidence of it during the interval, and also because he was examined repeatedly after his admission and no murmur was detected. Subsequently a cardiac inflammatory process developed itself suddenly after the decline of the joint-symptoms, and when the patient was apparently rapidly improving. A cardiac lesion affecting such an important valve as the mitral announces itself by a decided murmur, as it does here. A lesion of this kind, so marked in degree, coming on late in the course of the disease, during convalescence from a second attack of articular rheumatism, in which the circulation does not appear to be affected by the heart-lesion, is certainly very unusual.

When we come to consider the therapeutics of the case, you see here an illustration of what to me is a growing conviction. When referring to the use of salicylates in this affection, I have called your attention to the absolute uselessness of salicylates in preventing cardiac complications. Here you have a strong case. Do not misunderstand me, however. I fully concur in the estimate of the value of salicylic acid or its salts in removing the symptoms of rheumatism, the pain and joint-affection; but I say that they are useless in preventing the occurrence of heart-lesions.

Let me say a few words about the alkaline treatment. When, in a case of rheumatism, you detect a commencing cardiac inflammation, *give alkalis*,—not only for their actual effect, but also to prevent the occurrence of persistent heart-complications. Give them in full doses. The object is to

saturate rapidly the system and defibrinate the blood, and, if possible, prevent deposits upon the valves. We also aim to keep up the secretions, and therefore give the alkali in combination with neutral mixture, so as to keep up the action of the kidneys. Alkalies, by altering the crasis of the blood and acting as depuratives, are the most valuable agents we possess in the treatment of inflammations complicating acute rheumatism, and especially for the cardiac complications.

Will the patient recover without permanent damage to his heart? It is too early to decide this important question; but the murmur is so recent that I think it will disappear, or at least does so to a large extent. If any lesion remain, it will only be a slight roughening of the valve.

In considering the question of further treatment, we will now give ten grains of iodide of potassium three times a day, while we diminish the alkali still more,—to two drachms of bicarbonate of potassium three times a day. He shall be well nourished, but without meat or much nitrogenized food. Starchy food, bread and vegetables, and a little milk, shall constitute, in the main, his dietary. Quinine shall be continued, eight grains daily. You may ask, Why give quinine at all? Simply, my reply would be, as a general tonic and with a view to preventing a relapse.

*ERYSIPELAS TREATED WITH PILOCARPINE;
RAPID DEFEVERESCENCE AND DECLINE OF
ALL THE SYMPTOMS.*

In concluding to-day's clinic I will show you two cases of facial erysipelas. Both are men, and I bring both of them before you on account of their treatment, and not to discuss their symptoms.

The first case is that of a laborer, occupying bed 39. He had an attack of erysipelas, commencing ten days before his admission. Ten years ago he says that he had a similar attack in his face. The present inflammation began in his left knee and leg, following a sprain. Three days after the injury was received, the erysipelas appeared in the knee, and the next day his face was also attacked.

The man states that he is of temperate habits and usually healthy. When admitted, he presented a well-developed case of erysipelas: the knee and leg of the left side were enormously swollen, and the inflammation extended from the ankle-joint

to half-way up the thigh; at the same time his face was disfigured by discoloration and swelling; the eyes were not entirely closed, but the skin was of a vivid red hue and shining; the hairy scalp was not invaded, although the inflammation extended to the forehead; his temperature varied during the first few days from 100° to 102° ; there was a trace of albumen in the urine at that time; pulse about 100, and of good volume; his bowels were constipated, his tongue coated, and he had no appetite.

Now, gentlemen, this man had been under treatment outside, but without checking the course of the disease. As to exactly what this treatment was we are unable to get any information. Finding him a very ill man, with this spreading erysipelas, we gave him pilocarpine, a sixth of a grain hypodermically every two hours, and afterwards an eighth of a grain. He was also purged with a mercurial pill. The pilocarpine, even with this repetition, did not produce any sweating after several doses had been given, and we therefore supplemented its action by twenty drops of the fluid extract of jaborandi given every second hour, which soon caused free sweating.

In about twelve hours after instituting this treatment, the erysipelatous inflammation was checked and began to decline. The temperature also went down from 102° to normal. Since that time the man has made rapid improvement, and is now convalescent. This morning, barring a little sweating of the forehead and some puffiness and wrinkling about the eyelids, you would not believe from his appearance that he had had erysipelas at all. From the leg also the swelling has disappeared, but there is free desquamation, and the skin underneath is still slightly red, though not swollen. There is some itching of the skin, of the leg particularly, but no pain. This man, for all practical purposes, is well. He is still taking twenty-drop doses of jaborandi three times a day, which acts as a diuretic, keeping up the flow of urine to two and a half to three pints a day; there is no longer albumen in his urine; there has been no marked effect from the pilocarpine upon the salivary glands, and no disturbance of the cardiac action; there is no murmur, anæmic or organic.

I have shown you this man as a marked

illustration of the value of pilocarpine and jaborandi in the treatment of erysipelas. Now I will show you a second case, similar in character.

This man hurt his nose by a fall ten days before admission, which was also on the 18th, and five or six days later he had an attack of erysipelatous inflammation upon the right side of his face. This also showed a spreading tendency, and soon involved the right ear. On the fifth day of the disease he entered the hospital, and his entire face was red, swollen, and shining. He was put upon exactly the same treatment as the preceding case. One-sixth of a grain of pilocarpine, followed by twenty drops of fluid extract of jaborandi, was given every two hours. The hypodermic injection was not repeated, because it had acted freely upon the skin. It did not increase the flow of urine, as in the other case, and did not increase the salivary secretion. The temperature upon admission was $103\frac{1}{2}^{\circ}$ in the afternoon, but after the hypodermic injection it declined almost immediately to 100° , and later in the evening it was $99\frac{1}{2}^{\circ}$. The next day it attained 101° , but it was not again to a fever-temperature, and soon fell to normal.

The erysipelatous process spread to the left ear upon the day following admission, but there has been no outbreak since, and the original inflammation rapidly subsided. The disorder was quickly influenced by the remedy. This patient had no quinine and no iron, simply the jaborandi. This treatment has been growing upon me for some years, and I can say that I believe it to be of value. You know that the usual treatment is by iron and quinine, and thus far this man has had neither. Certainly these agents do exert some influence upon the disease and relieve the inflammation. We, however, have had better results from the jaborandi than from the preceding mode of treatment. My experience, of course, is more with what physicians call erysipelas, and in our first case, where it seemed to follow a sprain, there may be a question whether or not it was the surgical form. I will confine myself, however, to my own observation, and speak of erysipelas as it comes under the eye of the physician, and I will say that I know nothing that has such an effect upon the course of erysipelas as jaborandi and its active principle, pilocarpine. They have been in

my hands of special service in cases in which the heart is not feeble nor the vitality depressed; and in those in which there is an acute beginning with high temperature, and with a tendency to rapid spreading. The demonstrated value of the pilocarpine-treatment in this class of cases renders it probable that it may also be of service in surgical erysipelas, and I have recommended it to our surgeons for trial.

TRANSLATIONS.

GAVAGE IN THE TREATMENT OF CONSUMPTION.—Débove and other French writers have during the last few years repeatedly commended superalimentation in the treatment of phthisical patients. In spite of the absence of appetite, the patients were obliged to take, by means of the œsophageal tube, large quantities of a mixture of milk, eggs, and so-called meat-powder (meat cut up small, dried over a fire, and powdered in a mortar), with the occasional addition of peptones and cod-liver oil. Dr. Peiper (*Deutsches Archiv f. Klin. Med.*, xxxvii.) has repeatedly tried the method in Mosler's clinic. In two cases the œsophageal sound was discontinued at the solicitation of the patients, however, and they were allowed to take their food in a natural manner. At the outset, half a litre (one pint) of lukewarm milk or bouillon was given with twenty-five grains of meat-powder, several eggs were added, and this quantity given twice daily; subsequently the milk and meat-powder were greatly increased, and given four times a day. With this the patients continued their regular diet, which was chiefly vegetable, with usually one bottle of wine daily; cod-liver oil and stomachics were given when required. Fourteen patients were treated in this way, with the following result: in two the condition became worse during the treatment; in the remainder, on the contrary, after a short time a marked improvement in their general condition was observed; strength and bodily weight increased, they were able to leave their beds, the appetite improved, attendant diarrhoea was checked, cough and vomiting were much reduced. Bacilli were not detected in the majority of the cases, however. The excretion of urea was greatly increased, sweating was less, and in two the hectic fever was favorably

influenced.—*Centralblatt für die Med. Wissenschaft*, April 17.

RAPID DILATATION OF THE UTERINE CAVITY.—M. Vulliet, of Geneva, at the meeting of the Academy of Medicine (Paris, April 6) demonstrated his new method of dilatation of the uterine canal and explained its application to the treatment of uterine affections. He places his patient in the genu-pectoral position, and after using a bougie or dilator he introduces three or four small tampons, which have been previously dipped in a ten-per-cent. solution of iodoform and dried; to each of which a double thread is fastened to facilitate removal, which should take place in twenty-four to forty-eight hours. The cavity is then washed out with an antiseptic solution, and new tampons inserted, and in this way continuing until maximum dilatation is reached, being careful not to leave the uterus empty if a good result is looked for. Laminaria tents, which have been also disinfected, may be employed if more rapid dilatation is desired at the end of three or four days. When dilatation is complete, the interior of the uterus is visible throughout its entire extent, and it is an easy matter to apply the actual cautery, or any other local treatment, in cases of cancer, polypi, or endometritis. With antiseptic precautions this procedure is without danger.

PHYSIOLOGICAL ACTION OF HYPNONE.—MM. Quinquaud and Laborde, having studied the action of hypnone, which has recently been so highly lauded as a sedative and narcotic in fever, reported at the last meeting of the Société de Biologie that it has asphyxiating effects. This confirms the results of M. Laborde's previous experiments. Therefore hypnone is not, properly speaking, a hypnotic remedy, but is much more of an asphyxiating agent.

ACTINOMYCOSIS IN MAN.—Before the Congress of the German Society for Surgery, held in April, Dr. Rotter, of Berlin, reported five cases, coming under his own observation, of actinomycosis in man.—*Deutsche Med. Zeitung*, April 19.

FOR ECZEMA OF THE HAIRY SCALP.—

R Glycerini, 100 gr.;

Acid. salicylic., 5 gr.;

Spiritus Mindereri, 25 gr.—M.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, MAY 15, 1886.

EDITORIAL.

ANNUAL MEETINGS OF MEDICAL
AND SURGICAL ASSOCIATIONS.

THE meeting of the American Medical Association held in St. Louis, Missouri, last week, as had been predicted in these columns, was successful and harmonious to an unusual degree, in spite of the newspaper efforts to create a disagreement among doctors. A calm reconsideration of the action of the Judicial Council in regard to the protest against the reception of delegates from the Philadelphia County Medical Society will satisfy any disinterested observer that the Council acted consistently and wisely in referring the action of the County Society to the State Society, with the papers. It was unfortunate that the Council had in the first place, on the day previous, decided the case hastily, before hearing all the evidence; but their right to take their report back again, before the Association took any action upon it, cannot be brought into question. The vote upon sustaining the chair in a question growing out of this report was unanimous, thus indicating the attitude of the members of the Association against those who disturbed its peace last year.

At this meeting two new Sections were proposed to be added at the next meeting,—one on Medical Jurisprudence, and one on Dermatology and Syphilis,—which will tend to increase the interest and value of the proceedings. A good suggestion was made by Dr. Eugene Smith, Chairman of the Section of Ophthalmology, etc., in his address, which the Committee of Arrangements might with advantage adopt at the next meeting. He proposed that

papers upon special subjects should be read before the general session, so that the whole Association could hear them: a discussion upon such subjects as ophthalmia neonatorum he thought might be useful.

Although something was gained by omitting the roll-call, yet several Chairmen of Sections were obliged to read their addresses only in abstract, on account of the short time left them. In the Sections the pressure was worse, and many papers were read only by title. An arrangement by which writers of communications would be obliged to send their completed essay thirty days in advance to the Secretary and Chairman of the Section to which it belonged, would enable the officers to act as censors, selecting the better and rejecting the poorer papers, and thus spare the members much loss of time.

The arrangements for registration were well planned, and thus confusion was avoided,—the members not being required to wait for their invitations, which were delivered subsequently from the temporary post-office established for the convenience of the Association in the same building. Much credit is due the Committee of Arrangements for their forethought and polite attention. During the sessions the *Weekly Medical Review* of St. Louis issued a daily edition, which was distributed to the members, containing accounts of the proceedings from day to day.

The dinner given by the Medical Press and Library Association to the visiting medical editors was the best entertainment that has yet been tendered to this Association, and was largely attended.

From conversations held with different persons during the meetings of the Association, the impression was obtained that there are abundant indications of success for the International Medical Congress next year, especially if a liberal appropriation is made by the national government towards entertaining our foreign guests.

The American Surgical Association, the

report of which is also contained in this issue, had a successful though not very exciting annual meeting in Washington, D.C. The papers were on practical subjects and the discussions valuable. This Society has done good work, and issues a handsome volume of Transactions.

MEDDLESOME MEDICAL LEGISLATION.

THE King of Servia, according to the journals, has issued the following: "Whereas it is irrefutably proved by science that the so-called antiseptic treatment of wounds yields more beneficial results than all other methods, we are pleased to order that henceforward the said antiseptic plan of treatment be solely employed in all the hospitals of our kingdom, and that corrosive sublimate and iodoform be used until our further disposition."

In a similar spirit was the prosecution and conviction of a physician in Germany last year for malpractice in not treating a patient by the antiseptic method. In our own country, four States—Georgia, Florida, Kentucky, and Virginia—have recently passed an act requiring morphine and its salts to be put up with scarlet labels and wrappers. If this rule be applicable to prescriptions (and it is manifestly designed to prevent mistakes by druggists in dispensing), it will greatly interfere with freedom in prescribing and hamper the physician in his duties, unless he should constantly carry a supply with him of morphine sufficient for his wants, which will tend to defeat the object of the law. In this form it is simply an additional example of mischievous medical legislation.

In order to prevent such errors, the Legislature needs to take counsel with good medical advisers. Medical legislation is a two-edged sword, and may injure medical interests, if not wisely planned, quite as much as it may protect if properly guided. We hope that our State Board of

Health will keep a good lookout for meddlesome medical legislation in this State, and oppose it at the beginning.

LEADING ARTICLES.

THE MUSCULAR DISEASE.

THE painstaking investigations of neuropathologists in the last few years have given us, if not exactly a new disease, at least a new pathology which has brought into unity and harmony a large number of apparently unrelated phenomena.

The Muscular Disease is the name which may be given to the results of their work, and it includes all those forms of progressive muscular atrophy in which the muscle itself is alone involved.

The Muscular Disease does not include the ordinary or spinal form of progressive muscular atrophy of the so-called Duchenne-Aran type, but does include pseudomuscular hypertrophy, the juvenile atrophy of Erb, the infantile progressive muscular atrophy of Duchenne, and other types. It goes without saying, therefore, that neuropathology is much simplified by the discovery of the true nature of these atrophies.

Muscular atrophy from various causes is extremely common. The most frequent and ordinary types are those produced by injuries and rheumatic or joint troubles, and by acute organic disease of the spinal cord and nerves.

Next in frequency is the atrophy which occurs as the result of a chronic disease of the spinal cord; while last and probably rarest are the progressive muscular atrophies due to a primary degeneration of the muscle itself. It is through the labors of Erb, Schultz, Gowers, Möbius, Leyden, Eichorst, Déjérine, Landouzy, and others, that this last class of atrophies in this various form has been shown to have an identical pathological basis.

There are now, therefore, clinically and anatomically, two broadly-distinguished types of progressive muscular atrophy,—viz., that due primarily to spinal, and that due primarily to muscular disease.

I. The spinal progressive muscular atrophies include not only the classical Duchenne-Aran type such as is ordinarily met with, but also glosso-labio-laryngeal

paralysis and progressive ophthalmoplegia externa. Amyotrophic lateral sclerosis is the same disease plus a sclerosis of the lateral columns of the cord.

In all these types the muscular atrophy and paresis are due to a degeneration and atrophy of the nutritive and motor cells at different levels of the spinal cord or medulla.

II. The primary muscular atrophy or muscular disease has as its anatomical basis a progressive degenerative atrophy of certain groups of muscles, accompanied sometimes by pseudo-hypertrophy.

Clinicians have divided the *muscular disease* into a large number of clinical forms, their divisions being based upon the groups of muscles attacked, the age of the patient when attacked, the presence of a pseudo-hypertrophy, and the *absence of any atrophy*, the muscular defect being then shown simply by weakness.

These types have received various names from the writers who first described them.*

The relations of these atrophies are best shown in the following table.

The primary progressive muscular atrophies of spinal origin.	{	Progressive muscular atrophy (Duchenne-Aran).
		Bulbar paralysis.
The primary progressive atrophies of muscular origin (the Muscular Disease).	{	Ophthalmoplegia externa.
		Irregular types,—e. g., scapulo-humeral form of Vulpian.
	{	1. Pseudo-hypertrophic paralysis.
		2. The family atrophies:
	{	(a) Juvenile atrophy of Erb.
		(b) Infantile progressive muscular atrophy of Duchenne.
		(c) The non-atrophic form of Charcot.
		(d) Other types classified (by Eichorst, Zimmerlin, etc.) according to the muscular groups first or most attacked.

* There are certain local muscular atrophies produced by over-use of groups of muscles. These are not progressive, and do not come under the term Muscular Disease.

The various types of the primary myopathic atrophies, as indicated above, have certain common characters clinically and anatomically. All of them are hereditary or occur in families.

There is generally no neuropathic history, and there are no marked nervous disturbances. The muscles are attacked in the order of their anatomical relations, and not in accordance with their physiological function or the nerve-distribution.

The disease generally begins in infancy or youth, but may attack at any age.

The degenerating muscles show no fibrillary contractions (as in the spinal form of atrophy).

There are no pure degenerative electrical reactions in muscle or nerve except in the very latest stages. Then we may find modal and even serial changes. The electrical formulæ are as follows:

		Galvanism.	Faradism.
Early in the disease.	Nerve.	Normal.	Normal.
	Muscle.	Normal.	Normal.
Late in the disease.	Nerve.	Normal.	Normal.
	Muscle.	$\left\{ \begin{array}{l} \text{CaCC= or} \\ < \text{AnCC} \\ \text{CaCTe} < \\ \text{AnCTe} \\ \text{AnOC=O} \\ \text{CaOC=O} \end{array} \right\}$	Normal.

The reactions are the same, therefore, as in the spinal form of progressive muscular atrophy, only in this latter case degenerative reactions appear sooner.

As in the spinal form, the muscle contracts and retains some power as long as it has any healthy fibres left.

There are no vaso-motor or secretory disturbances as in the spinal form. The disease progresses very slowly, sometimes stopping in its progress, and it may last for twenty or thirty years. It begins insidiously, attacking one-half the face or the shoulder and arm muscles, or lumbar and leg muscles.

The great variation in the development of the atrophy has led to much confusion and to an unnecessary attempt to differentiate "types." The following classification is given in order to illustrate this, and also to show the clinical groups and the symptomatology of the disease. There is no real necessity, however, for such numerous and finely-drawn distinctions.

Classified according to the age at which the disease begins, we have—

I. The types that begin exclusively in infancy or before the age of twenty-one. These are: (a) Pseudo-membranous hypertrophy; (b) Erb's juvenile form of progressive muscular atrophy, and certain allied and doubtless identical types described by Leyden and Möbius.

II. Beginning at any age. This includes the so-called infantile progressive muscular atrophy, which sometimes sets in after twenty-one, and other types of family atrophies.

It is very evident that age is no criterion upon which to classify the types of this disease. It is a fact that most cases begin in infancy or youth, and that is about all that is brought out by such attempts.

A second classification is based upon the group of muscles first attacked. Thus, we have—

1. Types beginning in the lower limbs: (a) Pseudo-hypertrophy; (b) Hereditary progressive muscular atrophy of Leyden, Möbius, Eichorst, Charcot.

2. Beginning in the shoulders and arm-muscles: Erb's juvenile form of progressive muscular atrophy and an allied form described by Zimmerlin and by Landouzy and Déjérine.

3. Beginning in the face or shoulders and arm: The infantile progressive muscular atrophy of Duchenne, which has been lately shown to be a primary myopathy by Landouzy and Déjérine.

Finally, we have a classification based upon the presence or absence of true or false hypertrophy, and we have a type described by Charcot, in which he claims that, although there is no atrophy or hypertrophy, yet it is the Muscular Disease because the muscles develop a progressive weakness.

It seems quite thoroughly established that, aside from the well-marked disease known as pseudo-hypertrophic paralysis, there may be some slight hypertrophy (true or false) in other types of these myopathies, more especially those occurring in children.

The cause of the myopathic atrophies is not known. They occur generally in families, and are the evidence of a degenerative taint. So that, doubtless, if we could learn the whole history, we should find some cause of the family vice.

Cases are apparently rare in this country, but it may be because they are not recognized; and it is hoped that this

article may stimulate physicians to be more on the alert.

Very little can be done in the way of treatment; but electricity, massage, roborant measures, and alterative drugs are indicated. The disease sometimes ceases to progress for long periods of time.

NOTES FROM SPECIAL CORRESPONDENTS.

PARIS.

SOME New Remedies and Therapeutic Suggestions.—Professor Hayem said last year that modern therapeutics might be defined as being a knowledge of indications and the art of fulfilling them. This year, in opening the spring course of lectures, he is not at all certain of being possessed of better knowledge as to the specific treatment of disease, as he says that the only specifics he is certain of are mercury, iodide of potassium, and quinine. At the same time he thinks that an important new set of indications is to be found in *disinfecting medication*, derived from the modern study of the micro-organisms. He defines the difference between simple medication and medical treatment by an example. Suppose we are called to a case of facial neuralgia, and after a careful clinical examination of the case we find that syphilis exists. Then we proceed to the treatment of that disease by specific remedies. But if there be nothing at all found to guide us, then we use medication for symptoms. Speaking of the treatment of hydrophobia by Pasteur's system, he explains that it is a preventive one, which attacks a process of incubation that is going on in the system and prevents its complete development, and there are hopes that some such system modified will yet give us the clue to the proper treatment of phthisis and other diseases.

Dr. Hayem, while on modern therapeutics, spoke of how, only a very few years ago, the professors of medicine took up, first of all, fever and inflammation as the most important of all the morbid processes; but we can now change this, because we know that *infection is the dominating element*, and fever and inflammation are only secondary symptoms. The idea of infection is not altogether new, as the ancients spoke of it; but its study is quite modern. Trousseau in his lectures hinted at it; but it was Davaine that first showed, in his study of the malignant pustule called "charbon," that the fundamental character of infection consists in some form of micro-organism. These ubiquitous microbes exist at all times and in all places. The present German idea of their development is that they are like tapeworm and similar parasites: that is, that they are all hatched

from eggs or some previous deposits of germinating matter. Certainly it is more than probable that the fully-developed specific microbe does not "wait around" for years for a favorable opportunity to attack us; but it is most likely passing through some form of evolution, being developed from one form of parasite to another. The important fact derived from the study of infection is that some sort of medication based on internal disinfection must be established; and Professor Hayem proposes to develop the latest efforts made in this direction in a series of lectures, which we will communicate in due course.

One of the newest attempts to prepare such remedies is *salol*, or *salicylate of phenol*. This is a new antiseptic that has been discovered by Professor Von Nencki, of Berne, Switzerland. It seems destined to take the place of salicylate of soda, first of all in the treatment of rheumatism, and it may also succeed many of the other antiseptics. The unpleasant taste of the sodium salicylate is known in all hospitals, and it so frequently produces nausea followed by a fainting-fit that for many patients it soon becomes intolerable. The new body, *salol*, is a white body, slightly greasy to the touch, and having a slight aromatic odor, but no taste. It is almost insoluble in water, but soluble in alcohol.

M. Von Nencki first tried it on animals, and found that all the *salol* given with the food was found in the urine in the form of urate of salicyl: so that in the organism there was only a simple decomposition without any modification of the composing parts of the *salol*. Following up his experiments, M. Von Nencki found that it was the pancreatic juice that caused this transformation,—so that it was in the duodenum, and not in the stomach itself, that the decomposition took place; from which fact he explained the absence of nausea, etc., in the administration of the drug. From six to eight grammes of it is now given per day. The urine of the patients becomes almost black, just as though they had taken carbolic acid itself; but there are no bad consequences found from this. Given in all the different rheumatismal affections, it has met with a greater success than the salicylate of soda, reducing all fever much quicker than the soda. It is also an antipyretic, and it has been tried in phthisis with a result of diminishing the temperature four degrees Centigrade (from 40° to 36°). It is advised to commence in these cases with small doses (0.50 centigramme). *Salol* would be indicated also in diabetes, as phenol is given. Again, it is given as a local antiseptic in all intestinal catarrhs, and, as Levachoff has demonstrated that salicyl dilutes bile, it may be given in typhoid fever to disinfect the ulcerations, and used also in cholera, and against all intestinal parasites. One of its important uses will most likely be in catarrhs of the bladder. Urine in which it was placed

kept without decomposition for over six weeks, and in all cases the patient's urine became completely aseptic. Again, *salol* is almost insoluble, and its use as an antiseptic in place of iodoform has already given such results that we may be able to get rid of the last-named disagreeable substance and the dangerous corrosive sublimate. If *salol* does not kill the bacilli, it certainly prevents their development: so it is suitable more than any other known substance to powder wounds with.

While on the subject of therapeutics and *materia medica*, something might be said about Professor Planchon's studies on the barks of *Remijia*. Most of the modern botanists had given up all ideas of finding quinine in any of the plants nearly related to the cinchona family; but in 1871 Hesse analyzed a bark having a peculiar appearance and found quinine in it. Fluckiger, who saw the bark, thought it was not a true cinchona, but some sort of plant of the same family. Later, in 1881, M. Arnaud announced the discovery of a new bark that contained a new alkaloid, cinchonamine. Lately M. Triana, Consul-General of New Granada, got a supply of these different barks, and Professor Planchon has been able to class them as follows: *Remijia pedunculata*, the one that produces the bark that has been called "cinchona cuprea," and *Remijia Purdieana*, which gives the cinchonamine of M. Arnaud. There are some important results to arise from the proper classification of these barks. First, it is of great moment to have all the sources of our most used and perhaps most important medicine, quinine; secondly, it is thought possible to cultivate these barks in Europe, and, if so, it certainly would be possible to do so in the United States. Since the *remijias* are much less impressionable to change of climate than the cinchonas, such climates as Florida ought to raise them. The greatest advantage in a medical point of view is that these plants contain important principles that are destined to great use in medicine. It is well known that quinine is not the only alkaloid found in the cinchonas; most of them contain cinchonidine. And so great has this source of impurity been that, up to the last edition of the French Codex, it was allowed that quinine with only a certain proportion of cinchonidine was sufficiently pure. As in the last Codex a reaction was given which permits chemists to detect it, the quinine is now much more free of it.

The *Remijia pedunculata* does not contain any of the cinchonidine, and contains from nine to eighteen per cent. of pure quinine. The result of this is that for the last few years the market is full of this bark and the price of quinine is very much lower: so that this new bark has given us a plentiful supply. The other bark of the same class does not contain any quinine: it is the *Remijia Pur-*

dieana; but it contains the new alkaloid called here cinchonamine. This principle is a very active one; but it is too soon yet to declare what it can do, though wonderful results are expected from it. Dr. Laborde is trying it in Professor Bécclard's laboratory. A dose of twenty-five centigrammes will kill a guinea-pig. Other effects have been produced, and it is thought that a remarkable new therapeutic agent has been found.

On the Normal Poisons that exist in the Organism, and on the Toxic Properties of Urine.—Professor Bouchard has for the past two years been employing his pathological laboratory at the Faculty of Medicine here in the study of the above question, and from time to time in his lectures and in his communications to the Académie des Sciences he gave the results. In a few days quite a large volume will be published on these studies and their applications to renal diseases. The chemical principles that constitute the human organism can all become very dangerous to it the moment they exist in abnormal proportions. For instance, oxygen, common salt, water, will kill if introduced in excess into our bodies. Chloride of potassium is mortal at a dose of eighteen centigrammes per kilogramme. Man, as well as the other animals, is certainly and constantly traversed by poisons that are introduced or formed in his body; but in the normal state he is protected against this intoxication by three principal agents: first, intra-organic oxidation, which will destroy certain poisons; second, the liver, which stops and destroys others; thirdly, the emunctories, which carry off the larger part of the danger. It is possible to appreciate the degree of toxicity of the poisons that pass through the body by determining the degree of toxicity of the substances that are expelled from each emunctory: that is to say, by calculating what mass of living matter can be killed by the substances that are eliminated in a certain time from each organ of excretion.

Dr. Bouchard calls *toxie* the unit of quantity that would kill a kilogramme of living matter, and adds to it all the different functions of excretion, calling the urine-unit *urotoxie*, the bile unit *choletoxie*, the skin-unit *dermo-toxie*, etc. He first of all takes up the toxicity of the urine, which has always been supposed, but has only really been studied experimentally this last five years, first by Feltz and Ritter in 1881, and since by Professor Bouchard, who last year gave the results of his experiments in his lectures. He found that an injection of ten, twelve, or fifteen cubic centimetres of urine in rabbits caused a contraction of the pupil that soon became punctiform; shortly afterwards an acceleration of the respiratory movements was noticed, with a diminution of their amplitude, then indecision in movements, sleepiness, and a con-

siderable augmentation of the urinary function, with frequent emissions of urine; the temperature fell, and death came without any convulsions. Experiments of control were made by the injection of water only, and in fact it was found, after a long series of trials, that the quantity of urine that would kill a kilogramme of living matter was variable; but an average urotoxie was represented by forty-five cubic centigrammes of normal urine in adult man; and urine does not kill by any mechanical action, but only by the poisonous matters that it holds in solution. The determination of the urotoxie has allowed Professor Bouchard to determine the coefficient urotoxie of man: that is to say, the quantity of urotoxies that the unity of weight would fabricate or manufacture in the unity of time. A man in good health will eliminate in twenty-four hours for each kilogramme of his weight a quantity of urinary poison that is capable of killing four hundred and sixty-four grammes of living matter. So that a man takes two days and four hours to manufacture in himself the amount of poison in his urine which, if not eliminated, would be capable of killing him.

Now, in regard to the variations of this toxic action during sleeping and waking hours, Dr. Bouchard gives some interesting details. Man eliminates during sleep much less urine than when awake, and, curious to say, it is at the same time denser and less toxic than that eliminated in the daytime. At the end of the period of wakefulness—that is, the moment we are going to sleep—the urinary toxicity is at a minimum. From this moment it augments in poisonous qualities during sixteen hours,—first during sleep, then during the first part of our waking hours. At the moment of waking up it is five times more toxic than during sleep; eight hours after waking it is at its maximum. From this moment it commences to run down in strength, and in another eight hours it returns to the minimum.

As to the real toxicity of the urine eliminated in sleep and that during waking hours, the urine presents also a difference in quality. That of sleep is always sure to have a convulsive action on animals; that eliminated in the day is not so, but is very narcotic. The difference is so great that one must operate with one or the other to see the effects. These trials will, it is hoped, have a practical purpose, as they will lead to a proper therapeutic treatment of urinary diseases.

The Direct Contagion of Typhoid Fever.—Dr. Joffroy having stated at a meeting of the Société Médicale des Hôpitaux that he did not believe that typhoid fever was contagious, Dr. Gérin-Rose said he was surprised to hear Dr. Joffroy say so, as well as others. For his part, he had a list of some three hundred and seventy-two cases, of which two hundred and four had been taken from Tenon Hospital,

and the rest from Bichat and the Lariboisière Hospital, and he had seen at least thirteen cases of direct contagion, among them one of the infirmiers, who had died of the disease. He therefore was of the opinion that it was at least contagious for those who were compelled to be in the same building and had to sleep in the wards with the fever-patients, and as long as the city did not send the senile and chronic patients to other hospitals he felt sure that it would be continued as a contagious disease.

M. Joffroy, replying, said that the facts cited by Dr. Gérin-Rose could not be invoked in favor of a theory of contagion, because even when typhoid fever was epidemic here there were very few cases in the hospitals themselves. He did not deny that it might be contagious to a very slight extent, but it was at least very much less so than diphtheria or puerperal fever.

Paraphimosis.—An interesting clinic was given on this subject at the Hôpital Laennec, by Professor Nicaise, which is worthy of attention. Dr. Nicaise said, "You have just seen in No. 17 bed a young man who is to-day cured of a paraphimosis, and I will speak of it, as there are some points that you should know to understand its mode of production, its consequences, and its spontaneous cure, with the treatment that must be employed."

"Our patient had a congenital phimosis, and, having retracted the prepuce, found that he could not replace it. When brought here we saw this state of affairs. There was an ulceration on the dorsal face of the penis whose borders were formed by the preputial mucous membrane on one side and the skin of the prepuce on the other, and its centre was constituted by the submucous tissue. The glans itself was swollen, and behind it was a ring or belt of tissue which was thicker below than above, and ulcerated behind in a deep furrow or sulcus. This furrow you remarked was not circular, but oblique from below forward; it was also more profound above than below: this is what we saw four days after the retraction."

"I made a slight effort at reduction; but the pain was severe, and I feared producing a tear in the inflamed and ulcerated tissue. I at once introduced a pair of scissors and made a section. This incision at once became enlarged of itself, and I could have reduced it at once, but I always prefer to allow it to reduce itself, and the next morning most of the œdema had diminished, taxis was spontaneous, and to-day the patient is cured. The treatment of these troubles varies according to whether ulceration exists or not. As long as there is no ulceration, try taxis. To succeed there are a number of ways. I prefer M. Le Fort's, who places the tips of his fingers behind the furrow and at the same time uses the thumb to press in the

gland. Another process is that of M. Mau-riac: he pulls back the skin, and, putting a finger under the prepuce, attempts to pull it forward over the finger, or a hair-pin with the bent end forward may be put under the prepuce and an attempt made to draw the constriction over it. Finally, there is the mode called total compression: this is to use a small Esmarch's elastic band, or even a linen band, and make compression from before backward, which will take all the blood out of the organ and often render the reduction easy."

"When there is ulceration, it is preferable to proceed at once as in this case, or make a simple *débridement* by cutting across where the constriction is the thickest. One single incision is all that is needed, and it is preferable not to attempt any reduction at once, but to allow it to operate spontaneously. If desired, circumcision can be practised; but I do not see any need of it. I will close by recommending you in these little operations, as well as in the more important ones, to insist on strict antiseptic treatment. The solution of carbolic acid used should be very weak, and, the operation once made, apply a simple dressing of iodoform. No fatty substances are needed in attempting the reduction, as they do more harm than good."

The death of Professor Bouchardat, after a long and painful illness, is announced. He was born in 1806, and was Professor of Hygiene at the Paris School up to a year ago, when he was retired on account of age. He was Dean of the Academy of Medicine since 1850.

We have your townsman Dr. E. O. Shakespeare in Paris for the last week or so, taking an interest in M. Pasteur's work and the other interesting pathological studies to be seen in Paris. There is a renewal of the epidemic of cholera in Brittany, and it is quite possible that the doctor can see some of it before he leaves France.

THOMAS LINN, M.D.

PARIS, April 19, 1886.

PROCEEDINGS OF SOCIETIES.

AMERICAN SURGICAL ASSOCIATION.

THE Seventh Annual Session of the American Surgical Association was held in the Army Medical Museum, Washington, D.C., April 28 to May 1, inclusive.

The meeting was called to order at 11 A.M., Wednesday, April 28, by the President, Moses Gunn, M.D., of Chicago.

After the calling of the roll by the Secretary, the President delivered his annual address, an abstract of which follows.

ANNUAL ADDRESS.

Fellows of the American Surgical Association,—Custom, if not organic law, requires the

President to open the proceedings at your annual meetings with a more or less formal address. My immediate predecessor, in his address one year since, suggested that either a résumé of the progress of surgery for the previous year, or some special scientific subject, should constitute the subject-matter of the President's address. I propose to comply with the spirit of this suggestion, and shall indulge in a few thoughts on certain points in the physiology and surgery of motor, sensory, and moto-sensory or compound nerves.

Previous to the investigations of Magendie and Bell, no clearly-defined effort had been made to differentiate the motor and sensory nerves. It remained for these investigators to establish clearly the fact of the motor qualities of the anterior roots and the sensory qualities of the posterior roots. With this also came the idea that this difference was intrinsic, and due to peculiarities in the anatomical and physiological organization of nerve-fibres. This appears to have been the idea generally entertained until very recently. Let us inquire, Is this a fact, or is the difference to be found in extrinsic conditions,—i.e., the anatomical organization at each end of the nerve,—the nerve-trunk being simply a conductor of a form of force? Upon the facts of the case depends the possibility of satisfactory results in the section and physiological reunion of divided compound nerves, and the grafting of one compound nerve upon another, where there has been so great a loss of the trunk of the nerve as not to permit the approximation of the distal and proximal portions of that nerve. Success in achieving satisfactory results by such operations, or a uniform lack of success, must afford a tolerably reliable answer to these interrogatories, much more reliable than experiments on some of the inferior animals. Experiments on animals require severe scrutiny, or they may mislead. Some of the experiments on animals were then referred to. Philippeaux and Vulpian divided in dogs the hypoglossal and lingual nerves and united the central end of the hypoglossal with the distal end of the lingual, and *vice versa*. The result of their experiments was that after a time motion and sensation were restored. Similar experiments were cited.

In April, 1880, Dr. E. P. Davis made for the speaker the following experimental operation. Under an anæsthetic the axillary plexus was exposed; the median was severed after its bifurcation, and also the ulnar and radial; the outer head of the median was united to the ulnar; the inner head of the median was united to the radial in the same way. At the end of ten days the dressing was removed, and complete paralysis of motion and of sensation found. In four weeks this began to disappear, and later a perfect condition of motion and sensation was observed. By this operation the distal portion of the median was left entirely without nervous supply, and

yet there was no paralysis of the muscles or integument supplied by this portion of the nerve. Later investigation showed that in the dog and certain other animals there is an anastomosis of fibres between different nerves, forming an indirect route for the conduction of nervous force.

It must be concluded from experiments that motor, sensory, and trophic powers depend not on the nerve-trunk itself, nor on a difference of nerve-force, but on the organism at the end of the nerve. Professor Stephani is reported to have succeeded four times in uniting the distal end of the median with the proximal end of the musculo-spiral, and the distal end of the latter with the proximal end of the former. Immediately following the operation there was complete paralysis and atrophy, but in the course of six or eight months there was not only restoration of muscular power, but also harmony of action to an extent sufficient to permit the animal to run; but extending power was not realized perfectly.

The intergrafting of a section of a nerve taken from an inferior animal to replace extensive loss of nerve-structure will probably be of too uncertain success to constitute a standard operation; but we may well ask, Can the grafting of the distal end of a nerve in such a case upon the side of or into the trunk of an adjacent nerve secure to it a supply of nerve-force? Experiments made by Kawa would indicate that such might be the case. To establish this point experiments on dogs are valueless, on account of the free nerve-anastomosis. We must look for the solution of this question to the rare opportunities met with in the course of surgical practice where accident institutes experimental operations on man. A case has been reported by Després, where there was such extensive destruction of the median nerve as to preclude the possibility of approximating its ends. He therefore engrafted the distal end of the median upon the trunk of the ulnar. Fifty-four days after the operation the functions of the parts supplied with the median nerve were partially restored.

On the 1st day of last December the speaker himself had occasion to resect more than three inches of the right ulnar nerve in the removal of a neuroma from a male patient, aged 36 years. The distal portion of the divided nerve was grafted into the trunk of the median; the sheath of the median was removed, and the broadly-chamfered end of the ulnar laid in contact with it and secured by three fine catgut sutures. Immediately after the operation there was complete paralysis of the parts supplied by the ulnar. On the eighteenth day there was a slight return of sensation along the ulnar side of the ring finger, and there seemed to be some contraction of the flexor carpi ulnaris. Four months after operation the patient could feel

a slight touch on the ulnar side of the ring finger; there was no sensation to touch in the little finger, but an increased warmth in it. He can now adduct the hand with considerable vigor, but as yet has no power over the terminal phalanges.

The positive evidence which these two cases furnish at so early a date warrants further effort in this direction, and corroborates the other evidence of the correctness of the postulate that the function of a given nerve depends entirely upon the machinery of its end-organs, and not upon any intrinsic quality in the nerve-trunk itself.

A proposition to form a Congress of American Physicians and Surgeons was read by the Secretary. It was discussed and referred to a committee of three, to report on Thursday morning. This committee was appointed, consisting of Drs. J. Ewing Mears, William T. Briggs, and Christopher Johnston.

Afternoon Session.—Dr. Christopher Johnston, of Baltimore, Maryland, read a paper entitled

DIAGNOSTIC LAPAROTOMY.

The rapid advance of abdominal surgery now demands the attentive consideration of surgeons, and requires the expression of opinion as to the position of the line limiting interference in certain classes of cases. The labors of gynecologists and surgeons have greatly lowered the mortality of laparotomy for ovariectomy and hysterectomy, but the pathological possibilities of the male and female abdomen still constitute many difficult problems, which the knowledge and zeal of surgeons are constantly striving to solve. The question arises, "How shall the seat of the pathological change be reached?" The answer is, "By laparotomy," which makes the diagnosis positive in cases of doubt, and is preliminary to other operations which may be required.

The propositions, then, are: first, that for abdominal surgical affections all possible operations ought to be attempted after the establishment of a precise diagnosis; and, second, that when a just diagnosis cannot otherwise be reached, it may and ought to be eked out by an exploratory incision. The mortality of abdominal incision without complication is low. A great consecutive mortality following a surgical procedure in no wise determines the want of value of the operation, while most cases recovering are to be considered a certain gain.

The abdominal incision intentionally diagnostic is fraught with comparatively so little ill consequence that its high value—even necessity—may be fairly claimed as an established and proper aid to diagnosis. Of all conditions requiring laparotomy, those involving the uterus and its appendages proba-

bly fill the largest space; next we have those involving the alimentary tract.

Besides being a justifiable operation, abdominal incision becomes the bounden duty of the surgeon in a great variety of instances. Fenestral exploration gains in facility and loses in danger by frequent repetition, and it might eventually render the exploratory laparotomy unnecessary.

When is exploratory laparotomy called for? It should be stated that to a certain extent every laparotomy is diagnostic. Two great classes in which exploratory laparotomy is demanded or permissible are to be recognized. First, all sorts of cases in which the diagnosis cannot be made without its aid; second, all those cases in which, a diagnosis having been made, no definite line of operation can be mapped out, and no abandonment of active measures be entertained or justified. As in these cases laparotomy holds the key, in all cases of doubt both as to what is the matter and what is to be done, it should be called upon to surrender that key. In intestinal cases the early operations are those which save life the oftenest; but abandonment ought not necessarily to follow delay in invoking the surgeon's aid.

DISCUSSION.

Dr. A. Vanderveer, of Albany, New York, remarked that experience shows us that simple incised wounds of the abdomen, without injury to the abdominal organs, will usually heal without difficulty, even if left to themselves. The mortality is very slight indeed. The cases which give us anxiety are those in which the bowel is injured and its contents escape into the abdominal cavity. These die inevitably if nothing be done. In these cases laparotomy should be performed. This is often opposed by the friends of the patient, and often by the attending physician. We have much to do in the direction of teaching the profession and the public the importance of early operation in these cases. Cases were cited of gunshot injuries of the intestine and of rupture of the intestine produced by external violence, in which the operation might have saved life if it had been permitted by the friends of the patient. The operation, as a rule, will not be permitted until the patient is in collapse; and it is then too late.

This operation should be done more frequently in the future than it has been in the past. As regards the mode of operation, the incision in the median line is by far the best. In some cases it would be impossible to reach the seat of disease by any other incision. In the closing of the wound, some recommend several lines of sutures, uniting the different layers of tissue separately. He believed that this was no advance on the old method of using sutures including all the layers of tissue. Where there is great distention of the bowel in intussusception, the discovery of the

seat of lesion is greatly facilitated by a procedure which he had seen Tait adopt in such a case. He opened the distended coil of intestine, permitted the gas to escape, and then closed the opening with sutures.

Dr. J. Ewing Mears, of Philadelphia, arranged the subject in this manner: first, external manipulation; second, internal examination, where this is possible; third, aspiration; and, finally, laparotomy. He considered laparotomy as much the most serious of all these methods. In this discussion the subject of laparotomy as a means of treatment does not call for consideration. He believed that the abdominal cavity should not be opened without due consideration. Death is a severe penalty to pay for the perfection of the diagnosis. We have already learned a great deal in regard to methods of diagnosis by external manipulation. The tendency at the present time seems to be in favor of opening the abdominal cavity rather than cultivating that essential skill by which the diagnosis may so often be made without resorting to operation. Tait's assertion that opening of the abdominal cavity is a matter of very little consequence has led many of the younger members of the profession to perform this operation without due consideration. Having exhausted other methods of diagnosis, he agreed with Dr. Johnston that, if the patient's life depend upon it, we should open the abdomen. He believed that in intestinal obstruction the abdomen should be opened, and that many lives have been lost by want of courage on the part of the surgeon. There is no question as to the duty of the surgeon in the case of gunshot wounds of the intestines.

Dr. Charles T. Parkes, of Chicago, Illinois, thought that the paper insists upon the necessity of exhausting all other methods of diagnosis before resorting to laparotomy. In the cases which he had seen where post-mortem examination followed, there was no evidence that the abdominal incision had anything to do with the fatal issue. In regard to operation in intestinal obstruction where the exhaustion is extreme, he recalled a case. Several years ago he was called to see a case of nine days' standing. The patient was in a state of extreme collapse. He was put to sleep and the abdomen opened; a small cyst was felt immediately beneath the fingers. Under the slight pressure it ruptured, and a quantity of offensive pus escaped into the abdominal cavity. This patient recovered. In such a case the best diagnostic skill could not determine the cause of the obstruction. In the case of a child 18 months of age, in which the operation was declined, intussusception of the small intestine was found at the autopsy, which was without adhesions, and could readily have been removed.

The abdominal opening should be made in the median line. In the closure of the wound, the simple suture going through all

the tissues has been followed by such good results that we need use no other. Where there is much distention of the intestine, he considered the method by opening the bowel the best. He had used the exploratory needle on several occasions, but it is necessary to make a number of punctures. In two instances he had found extravasation of fecal matter through these punctures.

Dr. McLane Tiffany, of Baltimore, during the last year had met with four cases of what he believed to be intestinal obstruction. In all four laparotomy was proposed. Two refused, and both of these died. Two accepted, and one of these recovered. The case that died was that of a woman, aged 73, in which the obstruction had lasted seven days. The intestine was enormously distended, and in the examination ruptured with the escape of the gas. After this it was extremely easy to find the seat of constriction. He thought the shock is likely to be less where the intestine is emptied. The time at which the operation should be performed must depend upon the acumen of the physician who sees the case. He agreed with the speaker as to the value of laparotomy as a diagnostic operation. It is not possible for any human being to recognize through the abdominal walls the manifold conditions of the organs present.

In regard to pistol-wounds of the abdomen, it frequently happens that the intestines escape injury, and in these cases it is a question when the operation should be done. The opening of the abdomen will not, in his opinion, do much harm. It is very desirable that there should be in hospitals special rooms devoted exclusively to this class of operations.

Dr. J. F. Thompson, of Washington, D.C., recorded two cases of laparotomy for the purpose of diagnosis. A woman, aged 36 years, had the history of an abdominal tumor lasting for several years. It presented the appearances of an ordinary ovarian tumor, with the exception that it had two sinuses communicating externally. One of the sinuses was traced back to the peritoneum without reaching any satisfactory explanation of the tumor. The peritoneum was then opened and the finger introduced, but no tumor in the cavity could be felt. Towards the abdominal wall a mass apparently embedded in the tissues could be distinguished. The wound was closed, and the patient recovered from the operation. The patient subsequently died, and the post-mortem showed that the tumor was an enlarged spleen which had fallen down below the umbilicus and had become attached to the abdominal wall.

The second case was one of apparently freely movable tumor in the right hypochondriac region. It was accompanied by excruciating pain. Operation was not recommended, but the woman and her husband insisted that something should be done, and,

therefore, after keeping her under observation for some time, the abdomen was opened. The tumor, probably carcinomatous, was found to involve the transverse colon, which ran directly through the mass. There was also an attachment of the growth to the liver. The abdomen was closed, the patient recovered from the operation, and is still living.

Dr. W. H. Carmalt, of New Haven, Connecticut, stated that some time ago he was requested to operate in a case of intestinal obstruction, but the collapse was so great that he thought that it would not be proper to do so. Within thirty-six hours the patient died. The post-mortem showed that the obstruction was due to a band of adhesion. If the operation had been performed early, the patient might have recovered.

Dr. Johnston, in closing the discussion, said that there was a certain amount of hesitancy on the part of surgeons in regard to operating in cases of abdominal injury, on account of the people and on account of juries. To overcome these objections, it is necessary to educate the public to the true state of affairs. In those cases where the bowel is opened laparotomy leads us to the seat of disease, and if anything can be done we are then able to do it. He was happy to find his opinions supported by so many of the able minds of the profession.

Thursday Morning Session.—A communication entitled

A CONSIDERATION OF THE BACTERIA OF SURGICAL DISEASES

was read by Harold C. Ernst, M.D., of Jamaica Plains, Massachusetts.

After an extended description of the various bacteria he had met with in wounds, chronic abscesses, erysipelas, and other surgical affections, and an account of numerous experiments on animals, with an exhibition of specimens in culture-mediums and under the microscope, he presented the following conclusions:

I. The experiments conducted over so long a time, with the successful inoculation at the end of that time, indicate very plainly the retention of pathogenic powers of these organisms indefinitely.

II. Their permanence of form is also well established.

III. In order to obtain either a modification of their pathognomonic forms or of their pathogenetic properties, if this is possible at all, some different methods of investigation must be used than those which have hitherto been employed.

IV. Probabilities indicate that work in this direction, however, is not likely to be successful.

V. So far as the experiments go, they tend to show that no form of the suppurative process in man is unattended by bacteria, and

that inoculation in the lower animals of pure cultures of these bacteria is always followed by more or less acute and extensive supuration.

VI. The above conclusion is supported by the evidence of all workers in this field of research.

VII. A number of different clinical phenomena may be produced by the same organism,—all of these phenomena, however, coming under the general head of the inflammatory and suppurative processes.

VIII. Differences in results produced by the same micro-organism in different individuals depend upon influences outside of the bacteria themselves.

IX. These differences are caused by variations in the amount of the infectious material received into the system, and the locality or lesions by which it gains access; and also by variations in the individual condition,—the personal equation being a very large factor in making up the sum of any results in clinical bacteriological investigation.

The paper was briefly discussed by Drs. S. W. Gross, J. S. Billings, N. Senn, and D. Prince.

The report of the committee appointed to consider the subject of

THE ORGANIZATION OF A CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS,

offered at the meeting of Wednesday by Dr. C. H. Mastin, was presented. The following is an outline of the main points of the proposition:

In view of the fact that there are a number of special medical organizations now in existence in the United States, each having for its aim the advancement of the special department of medicine for which it was organized, and since the members of the said special societies are the representatives of the profession in America, many of whom are at the same time members of several of these special societies, attendance on the meetings requiring separate trips from home, often with much loss of time; therefore it appears necessary that some arrangement should be made with the different societies as to a uniform place and time of meeting.

The plan proposed is to unite the following-named Associations, under the title of "A Congress of American Physicians and Surgeons:" the American Surgical Association, the American Ophthalmological Association, the American Otological Association, the American Neurological Association, the American Laryngological Association, the American Gynecological Association, the American Dermatological Association, the American Climatological Association, and the American Clinical and Pathological Association.

The plan of organization is as follows. Each society is to elect its own officers, hold its own sessions apart from the others at the

time and place of meeting, publish its own transactions, and do all other acts which, by virtue of its constitution and by-laws, it has the inherent right to do: thus preserving its own autonomy.

The Congress to be composed of these special societies, when in convention, and its meetings to be held in the city of Washington; the constitution and by-laws of the Congress to be formed by a committee of like number from each special society. The opening session of each annual meeting of the Congress to be devoted to such general business as may pertain to the interests of the Association as a whole; the Congress being presided over by a President elected annually, and who must deliver an opening address on the first day of the session. The President to be chosen by a nominating committee of one from each special society; the Presidents of the special societies to be *ex-officio* Vice-Presidents of the Congress. Membership in the Congress to be acquired only by virtue of Fellowship in one or another of the special organizations. The other officers to be elected as determined upon by the convention in session.

Any intention of offering an obstacle or opposition to any other organization in America was disclaimed. It is proposed simply as a plan of uniting into one great body the already existing special societies; and this plan is prompted by an honest conviction that such a union will prove of inestimable benefit to them individually and collectively.

The committee reported that they viewed with great satisfaction the perfection of a plan through which the meeting of the above-named societies at the same time in Washington may be accomplished, and recommended the adoption of a resolution that a committee of five be appointed, to confer with committees from other special organizations, to arrange details, and to report at the next annual meeting of the Association. The report was adopted. The President stated that he would name the committee to-morrow.

Afternoon Session.—The first paper presented was one by N. Senn, M.D., of Milwaukee, Wisconsin, on

THE SURGERY OF THE PANCREAS AS BASED UPON EXPERIMENTS AND CLINICAL RESEARCHES.

The following conclusions were submitted:

I. Restoration of the continuity of the pancreatic duct does not take place after complete section of the pancreas.

II. Complete extirpation of the pancreas is invariably followed by death, produced either by the traumatism or by gangrene of the duodenum.

III. Partial excision of the pancreas for injury or disease is a feasible and justifiable surgical procedure.

IV. Complete obstruction of the pancreatic duct, uncomplicated by pathological conditions of the parenchyma of the organ, never results in the formation of a cyst.

V. In simple obstruction of the pancreatic duct the pancreatic juice is removed by absorption.

VI. Gradual atrophy of the pancreas from nutritive or degenerative changes of the secreting structures is not incompatible with health.

VII. Physiological detachment of any portion of the pancreas is invariably followed by progressive degeneration of the glandular tissue.

VIII. Extravasation of pancreatic juice into the peritoneal cavity does not produce peritonitis.

IX. Crushed or lacerated pancreatic tissue is removed by absorption, provided the site of operation remains aseptic.

X. Complete division of the pancreas by elastic constriction is never followed by restoration of interrupted anatomical continuities.

XI. Limited detachment of the mesentery from the duodenum, as required in operations upon the pancreas, is not followed by gangrene of the bowel.

XII. In all operations upon the head of the pancreas, the physiological attachment of the peripheral portion of the gland should be maintained by preserving the integrity of the main pancreatic duct.

XIII. Partial excision of the splenic portion of the pancreas is indicated in cases of circumscribed abscess and malignant tumors, in all cases where the pathological product can be removed completely without danger of compromising pancreatic digestion or of inflicting additional injury upon important adjacent organs.

XIV. Ligaturing the pancreas at the point or points of section should precede extirpation as a prophylactic measure against troublesome hemorrhage and the extravasation of pancreatic secretion into the peritoneal cavity.

XV. The formation of external pancreatic fistula by abdominal section is indicated in the treatment of cystic abscess, gangrene, and hemorrhage of the pancreas due to local causes.

XVI. Abdominal section and lumbar drainage is indicated in cases of abscess or gangrene of the pancreas where it is found impossible to establish an anterior abdominal fistula.

XVII. Thorough drainage is indicated in cases of abscess and gangrene of the pancreas with diffuse burrowing of pus in the retro-peritoneal space.

XVIII. Removal of an impacted pancreatic calculus in the duodenal extremity of the duct of Wirsung by taxis or incision and extraction should be practised in all cases where the common bile-duct is compressed or ob-

structed by the calculus and death is threatened by cholæmia.

XIX. In such cases, the principal source of danger, extravasation of bile into the peritoneal cavity, should be avoided by preliminary aspiration of the dilated bile-ducts, accurate closure of the visceral wound with fine silk sutures, and absolute physiological rest of the organs of digestion during the time required in the healing of the visceral wound.

Remarks in discussion were made by Drs. P. S. Conner, of Cincinnati, A. Fenger, of Chicago, and Parkes, of Chicago.

Dr. Charles T. Parkes, of Chicago, Illinois, read a paper, supplemental to his paper of last year, reporting

TWO CASES OF CHOLECYSTOTOMY, BOTH ENDING FATALLY.

Case I. was that of a woman who had suffered with gall-stones for six years. The attacks of colic occurred at times as frequently as every week. Operation being decided upon, Dr. Parks performed cholecystotomy. The gall-bladder was found contracted, and reached with difficulty. Forty-three calculi were removed:

Case II. was that of a married woman, who for the past two years had suffered with attacks of pain lasting four or five days out of each week. There were jaundice and other symptoms of obstruction of the flow of bile. There was enlargement of the liver. The operation showed that the gall-bladder contained no calculi, but that the obstruction was caused by a body outside, which seemed to be an encysted calculus pressing on the duct. The gall-bladder could not be found. The patient died within twenty-four hours, and the post-mortem revealed the shrunken gall-bladder with the induration, which contained a gall-stone, pressing on the duct.

In discussing the paper, Dr. W. H. Carmalt related a case of obstruction of the gall-duct by calculi, with operation and recovery.

REPORT OF A CASE OF FATAL CESAREAN SECTION.

A case simulating and believed by all consultants to be abdominal pregnancy at full term was presented by the Secretary in the absence of the author, Dr. John B. Coleman, of Augusta, Georgia. The writer was requested to see S. A., colored, primipara, 24 years old, February 27, 1886. The attending physician believed her to be the subject of extra-uterine pregnancy. She believed herself to be at the end of gestation, and for three days had suffered with pains which were only quieted by the administration of laudanum. The entire abdomen was greatly distended, particularly in the upper portion. Vaginal examination showed procidentia, the os projecting three inches beyond the labia. The os was sufficiently patulous to permit the entrance of the

index-finger. Rectal examination gave negative results. Palpation and auscultation showed the position of the fœtus to be dorso-anterior and obliquely transverse. Placental souffle could not be heard. The abdomen was so large and the fœtal heart sounded so distinct that the reporter also concluded that the case was one of extra-uterine pregnancy. The patient was examined by a number of surgeons, who agreed in the diagnosis. The history and the symptoms indicated that the patient was at the full term of pregnancy, and it was decided that immediate surgical interference was imperative.

On March 3 the patient was operated upon. An incision six inches in length was made in the linea alba. The tumor exposed much resembled the pregnant uterus. The incision was extended above the umbilicus, and it was positively determined that the case was one of uterine pregnancy. The uterus was drawn forward and its anterior wall cut through. He had not conceived it possible for the uterine tissue to be prolonged from the epigastrium to three inches beyond the vulva. A vigorous female child, weighing seven or eight pounds, was removed. The hemorrhage was not great. The placenta was removed without difficulty. The incision in the uterus was closed with deep and superficial catgut sutures. The peritoneum was closed with a continuous suture, and the abdominal wall with hare lip pins and superficial sutures. Antiseptic precautions were adopted throughout the operation, but septicæmia subsequently developed, the patient living four days.

Friday, Third Day, Morning Session.—Dr. T. F. Prewitt, of St. Louis, read the first paper, entitled

TRAUMATIC ANEURISM OF THE INTERNAL CAROTID ARTERY.

E. J., colored, 17 years of age, was shot by her husband early in January, 1885. The weapon used was a revolver carrying a No. 32 ball. The shot was fired at a distance of two feet, and entered the cheek over the malar bone, ranging backward. There was rather profuse hemorrhage from the wound of entrance. There was no wound of exit. The bleeding was controlled by compression. There was hemorrhage from the ear at the time, and this recurred on two or three occasions. For some time after the accident the patient stated that there was some hemorrhage from the mouth and nose on rising in the morning. There was slight swelling at the time, which gradually increased until April 2, when she was seen by the speaker. It then projected into the pharyngeal cavity, and rested against the uvula and extended externally from the anterior petrous portion of the temporal bone to the hyoid bone. The swelling pulsated in every direction, and gave

thrill and bruit. Immediately after the accident there was paralysis of taste and of the right side of the tongue. This continued.

With this history and with these symptoms, it was decided that there was an aneurism of the internal carotid artery, and that the vessel had been wounded near the carotid foramen.

It was determined to ligature at once the common carotid artery. The usual incision was made, and the dissection continued until the artery was exposed. A silk ligature was passed from behind forward. The vessel was then lifted, to be sure that the pulsation was arrested before the ligature was applied. Finding that it was, the vessel was then tied. The pulsation was at first arrested, but in a few minutes it could be again felt. In the absence of all precedent, it was concluded to extend the incision upward in front of the tragus, and determine the feasibility of opening the sac and tying the distal end. An incision was then made below the ear, and extended upward back of the ear. A cautious dissection revealed the fact that the sac filled all the space between the mastoid process behind and the condyles and ramus of the jaw in front. It extended to the base of the skull, to which it was closely adherent. It was therefore impossible to reach the artery in that direction. Further attempts were abandoned, the wound was closed, a drainage-tube inserted, and an antiseptic dressing applied. On the eighth day there was some hemorrhage from an opening near the angle of the jaw. This was repeated, and she spat up some blood on the following day. Examination showed a little coagulum at the angle of the jaw, which was removed, and the left forefinger thrust into the opening. No coagulum could be felt within the sac. The attempt to detect the entrance of the artery with the finger failed. In order to avoid the hemorrhage which would follow the removal of the finger, the sac was stuffed with lint treated with iodoform. This controlled the bleeding. The patient gradually became weaker, and died on the twenty-fifth day after operation, from exhaustion. Ten days after the sac was stuffed, epileptiform convulsions involving the facial muscles and the flexors of the forearm and hand appeared. These continued at intervals until her death.

The post-mortem showed the ball in the posterior part of the sac. The opening of the carotid artery was found close to the carotid foramen, and seemed blocked up with clot. The blood-vessels of the membranes of the brain were congested, particularly on the right side. The inferior petrosal and lateral sinuses were filled with thrombi up to the torcular Herophili.

The differential diagnosis of aneurism of the internal carotid artery from those of other arteries in this situation was then considered. As regards operation in this case,

compression and ligation were considered; but compression was rejected, on account of the urgency of the symptoms. The patient was not a suitable one for this mode of treatment, being ignorant and irritable, and unfitted to endure the annoyances of this method of treatment. Neither were skilled attendants available.

Discussed by Drs. Thompson, Briggs, Agnew, Vanderveer, and Tiffany.

Dr. Roswell Park, of Buffalo, exhibited a tracheotomy-tube, a bivalve instrument, the blades opening laterally and provided with an obturator permitting its ready introduction. The great advantage claimed for the instrument was the ease with which it could be cleansed.

The next paper, by Roswell Park, M.D., of Buffalo, was entitled

LIPOMA TESTIS, OR A LARGE ACCUMULATION OF FAT IN THE TUNICA VAGINALIS.

J. P., aged 40, was first seen in September, 1885. For eighteen months the patient had noticed a slow but continuous enlargement of the right testicle. This was almost painless, but caused inconvenience by its weight. At this time the tumor had reached the size of a cocoanut.

Examination showed the scrotum to be filled with a large mass, the testicle being crowded into a small space at its upper part. This mass was solid, yet soft and not tender. Obscure fluctuation was noticed, but no fluid was obtained upon explorative puncture. The patient's general appearance excluded all idea of malignancy. The scrotal integument moved with perfect freedom over the tumor.

On October 4 the patient was operated upon. A free incision through the tunica vaginalis revealed a mass of densely-packed fat, which was slightly adherent, but was turned out without difficulty. On separating the lobular masses by the fingers, the right testicle was found not merely embedded in its upper part, but incorporated by apparently intimate tissue-connection. It was supplied with blood both from the testis and from the cord. The cord seemed to pass for a distance of two inches through the mass before reaching the testicle. No evidence of past or present hernia could be found, the ring and canal being no larger than on the opposite side. Finding the fibrous trabecula and blood-vessels radiating from the testicle to the fatty mass so numerous and distinct, it was decided to remove the whole mass, which was done. The patient recovered without incident. After removal the mass weighed three pounds. It was not possible to decide the exact origin of the fatty growth, whether it had started from the cord or from the testicle.

The literature of this subject is very meagre, the author being able to find but three similar cases on record.

Dr. Park also read a paper entitled

NEPHRECTOMY ON A PATIENT TWENTY-THREE MONTHS OLD.

B. B., born October 4, 1883, appeared at birth to be perfectly healthy. During the following winter the nurse noticed an enlargement in the right side of the abdomen, and the attention of the attending physician was called to it. The case was seen by Dr. Moore, who considered it a tumor of the right kidney.

July 31, 1885, the attention of the writer was called to the child, who appeared to be perfectly healthy. There was a history of steady enlargement of the growth. The bladder was examined with the sound, but no evidence of calculus was found. The urine contained numerous crystals of triple phosphates; otherwise normal. Examination of the abdomen revealed a firm resisting tumor, about the size and shape of the foetal head at term, occupying the right half of the abdominal cavity. A portion of the fluid was removed and examined, with negative results. The diagnosis was fibro-cystic tumor of the right kidney, probably of congenital origin. Five weeks later the tumor was found to have increased decidedly in size, and operation was decided upon.

The operation was performed September 15, 1885. An incision was made in the right semilunaris. Slight adhesions were found. The peritoneum covering the growth was incised and the tumor shelled out without much difficulty. The pedicle was tied and dropped into the abdominal cavity. On the twelfth day the patient was removed to his home, and now, seven months after operation, is perfectly well. The tumor proved to be a fibro-cystic tumor of the right kidney, the cystic element predominating. Immediately after removal it weighed four pounds.

In searching the literature of this subject, the writer had been able to find but three cases in which the age of the patient approximated that of the one now reported. These cases were, respectively: one, two and one-fourth years, recovered; one, two and one-half years, died; and one at eleven months, death. The case reported, therefore, appears to be the youngest which has survived nephrectomy, he being twenty-three months old at the time of operation. The abdominal incision in this case was made not from choice, but from necessity, the tumor being altogether too large for extraction through a small opening in the lumbar region.

Dr. W. W. Keen, of Philadelphia, then read a paper on

STRETCHING OF THE FACIAL NERVE.

He related a recent case, that of a woman aged 48 years. She had had severe attacks of nervous trouble in early childhood, and had twice been paralyzed. Five years ago, coincident with menstrual disturbances, her right eyelids began to twitch, and in six months the whole face and the platysma were

incessantly in spasm, which was increased by mental or muscular effort, such as eating, speaking, or being spoken to. Later, this was accompanied with constant pain.

In June, 1884, the right infra-orbital nerve had been resected, with partial relief for only six weeks. Not long after the twitching extended to the right side and leg.

April 2, 1886, Dr. Keen cut down on the seventh nerve by an incision behind the right ear, displacing the parotid gland forward and getting access to the nerve just after its exit from the stylo-mastoid foramen. Embedded in connective tissue, it required considerable search and dissection to lay bare the nerve in this case. The exact point of its entrance into the parotid was quickly discovered by a very weak current of electricity, one electrode being placed on the cheek, and the other, consisting simply of the wire from the cell, being touched at successive points from above downward. The trunk was then laid bare and stretched, the force being estimated at four or five pounds, just short of lifting the entire head.

Total facial palsy followed, with relief not only from the spasm in the face and neck, but also of that in the side and leg. The wound healed in four days, when the sutures were removed, the highest temperature having been 100.4°. The operation was done twenty-five days ago, and so far there has been no return of the spasm, and the patient was delighted with the result, the palsy being a grateful relief from the spasm.

He called attention to two cases in which a palsy existing prior to the operation was benefited by the nerve-stretching, both electrical and voluntary control being obtained to some extent, and he suggested that in persistent facial palsy stretching of the facial nerve be tried as a therapeutic operation.

The discussion of Dr. Keen's paper was postponed to the afternoon session.

Afternoon Session.—Dr. C. H. Mastin, M.D., of Mobile, read a paper on

SUBCUTANEOUS DIVISION OF URETHRAL STRICTURE.

The speaker enumerated the indications which render the operation necessary, and then described an operation which he had employed with entire satisfaction since 1868. The patient, being properly prepared, is put in the ordinary position for cystotomy. An anæsthetic is administered. A tube, open at both ends, is then passed down to the stricture. This protects the walls of the urethra, and puts on the stretch the face of the stricture. The tube is then filled with small whale-bone probes, and one after another is tried, with the hope that one will enter the stricture. This being accomplished, the tube and probes are removed. The probe engaged in the stricture is then pushed forward, and a Wheel-

house sound carried down to the stricture. An incision, one-half inch in length, is then made in the anterior wall of the urethra on the groove of the sound. The sound is withdrawn a short distance, and the whalebone probe sought for as it passes through the stricture and drawn out of the original wound. Over the probe a gorget is passed having its blade upward. This is passed downward, cutting the stricture on its superior face. A catheter is then passed along the entire urethra into the bladder and the urine evacuated. The stricture is then examined, to determine whether or not any points of narrowing still remain. If there are, they are divided.

If in the first instance it is found impossible to pass the whalebone bougie, a staff with a deep groove is passed to the stricture and a small opening made. A whalebone bougie is then passed through the stricture and the parts thoroughly washed with cold water. The operation is completed as in the previous case. After operation a full-sized ordinary soft catheter is introduced to the prostatic portion of the urethra, but not into the bladder. The patient is put to bed on the left side, and directed to push the catheter into the bladder when the desire to urinate is felt, and to withdraw it beyond the neck of the bladder, but not through the stricture, after the urine has been passed. This is used only for the first twenty-four or thirty-six hours, to protect the wound from the contact of the urine. The speaker was opposed on general principles to allowing a catheter to remain in the bladder. At the end of the time mentioned the catheter is dispensed with. Immediately after the stricture has been incised and the calibre of the urethra restored, the external wound is closed with three fine pins, passing sufficiently deep to grasp the walls of the urethra. These are removed in from four to six days. In the course of eight or ten days the patient is able to return to his work. The maximum calibre of the urethra is restored by the use of graduated sounds.

The advantages of this operation are the short time of confinement for the patient, the freedom from hemorrhage, the quick union by primary adhesion, and the small amount of cicatricial tissue left.

Discussed by Drs. Danbridge, Prince, and Dunott.

Dr. J. Ewing Mears offered an amendment to the by-laws providing for the appointment of a committee of five, of which the President shall be chairman, to have charge of the preparation of the scientific work of each session. Laid over until the next meeting.

The President announced the following committee on the proposition looking to the formation of a congress of American physicians and surgeons: Drs. C. H. Mastin, Charles T. Parkes, J. Ford Thompson, J. Ewing Mears, and N. Senn.

The officers elected are as follows:

President.—Hunter McGuire, M.D., Richmond, Virginia.

Vice-Presidents.—T. F. Prewitt, M.D., St. Louis, and J. W. Gouley, M.D., New York.

Secretary.—J. R. Weist, M.D., Richmond, Indiana.

Recorder.—J. Ewing Mears, M.D., Philadelphia.

Treasurer.—P. S. Conner, M.D., Cincinnati.

Council.—Drs. Hunter McGuire, John S. Billings, A. McLane Tiffany, R. A. Kinloch, and Moses Gunn.

Honorary Members.—Foreign, Sir William McCormac; American, Prof. Henry J. Bigelow.

Active Members Elected.—Drs. H. H. Mudd, St. Louis, and Joseph Ransohoff, Cincinnati.

Time and Place of Next Meeting.—The second Wednesday of May, 1887, at Washington. Adjourned.

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND.

THE Eighty-Eighth Annual Meeting of this Association was called to order at noon of April 27, in their hall at Baltimore, by the President, Dr. John R. Quinan. The usual order of business, including registration of delegates, reports of officers and committees, and the President's address, occupied the first day's session.

Dr. Quinan, after devoting the early part of his address to the laudation of the heroism of hard-working, conscientious physicians, and especially to that shown by certain ones whom he named, occupied the remainder of his time in discussing medical legislation in Maryland, and what rights the "Faculty" has under its charter granted in 1799. It appears from this charter that no one is allowed to practise medicine in any of its branches without first having obtained a license from an examining board appointed by the "Faculty." This charter is really an act of Assembly and a law of the State. It has never been repealed or changed, though not carried out for some fifty years or more.

The careful investigation of the subject, with a request for the best plans of action to be adopted, was referred to a special committee for future report.

The second day's proceedings opened with an able address by Colonel George E. Waring on "The Removal and Destruction of Organic Waste."

He began by stating that a large number of diseases are the result of the way in which people live, and that organic waste is inseparable from human life. By the proper removal and destruction of this waste the death-rate can be materially lowered, and some

diseases (of which typhoid fever is a type) can be prevented. He cited at considerable length statistics from English sources in proof of the statement, especially some very interesting ones concerning the army. Cholera kills fewer people than do diseases of the above-named types. Cholera has been a blessing instead of a curse, by causing more thorough and diligent sanitation, and preventing deaths from enteric and other fevers of preventable character. It also shows the utter futility of quarantine and the great benefit of internal sanitation.

Statistics were quoted from the census report showing that annually one hundred thousand deaths occur in the United States from preventable diseases.

Reference was made to the system of Paris, where tightly-sealed vaults are used. But typhoid fever is constantly present in fatal form. The best solution of the question has not yet been reached. The plan proposed by Colonel Waring was illustrated by supposing its application to a town of ten thousand inhabitants, in which we had the means and power to carry it out. Laying aside the provisions for storm-water or other abnormal waste, the plan provides for the average diurnal amount, which can easily be estimated.

Pipes six inches in diameter (which have a capacity of twenty cubic feet per minute, while the demand will be only four) are laid throughout the town. These have a proper fall, and connect with one fifteen-inch pipe, which carries all the wastes to the place of destruction at some distant point.

The destruction can be accomplished in one of three ways.

First. By emptying into a large and rapidly-flowing stream of water.

Second. By spreading over a surface of ground sufficient to absorb the materials.

Third. By emptying upon a tract of very porous land, natural or artificial, which acts by filtration.

Though any of these plans can be safe, it also is capable of great harm.

A necessity strongly insisted upon was the daily automatic flushing of the entire system.

The only safe way to dispose of organic waste is by immediate removal and destruction.

After this address, the report of the Section on Surgery was called for. Dr. Chambers, the Chairman, read a paper on the "Proper Treatment in Chronic Suppuration of the Glands of the Neck." Whether of tuberculous or scrofulous character is not positively proved, but they will undoubtedly in time produce tuberculosis, and hence are dangerous associates. The doctor therefore recommended their removal early and completely. Several cases were related.

Dr. Winslow, of the same Section, reviewed the recent work and literature on "Penetrating Wounds of the Abdomen," "Treatment

of Intestinal Obstruction" (in which he condemned the methods of Mr. Hutchinson, of England, and favored laparotomy, also mentioning two successful cases recently occurring in this city, one being his own, the other that of Dr. West), and "Pyloric Stenosis."

Dr. Branham presented "Clinical Notes" of a number of cases showing peculiar departures from the usually natural symptomatology.

The fourth day's session opened with the report from the Section on Obstetrics and Gynecology. Dr. B. B. Browne, the Chairman, read a paper on "The Curette as a Diagnostic and Therapeutic Agent in Obstetrics and Gynecology." His conclusions are epitomized as follows:

1st. That its use is less painful and less likely to set up cellulitis than ordinary caustic and alterative applications.

2d. That it is an important diagnostic agent in all obscure affections of the uterus.

3d. That it is more effective for the removal of endometric growths than any other agent.

4th. That its proper use after abortions will prevent hemorrhage and septicæmia.

5th. That after labor the antiseptic fingers or hand used as a curette for complete evacuation of the uterus will lessen the danger attending the puerperal woman, will prevent fetid lochia, and will hasten the period of involution.

This was followed by Dr. Miltenberger, of the same Section, with a paper on "Puerperal Eclampsia." This was one of the ablest and most instructive papers of the entire meeting. After citing the death-rate at various periods up to the present, which is about eleven per cent. (which the author thought by careful previous treatment and proper management at the time of convulsions could be yet further reduced), the lecturer gave a careful analysis of the symptoms.

He discards the uræmic theory of its pathology, believing the origin to be in the medulla oblongata. He regards the convulsions as due to one of two causes, centric or eccentric irritation. Much interest was manifested in the views presented as to the treatment, and considerable discussion evoked.

Two statements are especially to be noted, the decided preference for craniotomy over version, and the strong advocacy of venesection in cases of centric origin, where there is congestion of face, neck, etc., especially if the patient is plethoric. This latter view was combated by Dr. Lynch, but endorsed by Dr. P. C. Williams, who were the principal members engaged in the discussion. Dr. Robert T. Wilson read a paper on a temporary clamp used in ovariectomy and allied operations. Dr. Cathell's paper was read by title and referred.

The session of the fourth day was occupied with the reports from the Sections on Materia

Medica, Necrology, and Sanitary Science. Dr. Rohé's paper, as Chairman of the last-named Section, owing to his absence was read by title and referred. Dr. Waters, of the same Section, discussed "Sewage and House-Drainage." The paper of Dr. R. H. Thomas, Chairman of the Section on Materia Medica, elicited discussion on the antipyretics. It was noted that they should be given in small doses frequently until the temperature is reduced to a safe condition, but that no attempt should be made to bring it down to normal or to keep it there.

The fifth and last day's session was occupied with reports from the Section on Psychology and Medical Jurisprudence and from committees, the reading of volunteer papers, and the election of officers. The committee on a lunacy bill reported such a bill as passed by the Legislature, signed by the Governor, and soon to become operative.

The committee appointed to secure the passage of a law establishing and maintaining an institution for the care and education of idiots and feeble-minded at the expense of the State, reported that such a bill had passed the Assembly, but had been killed in the Senate.

Dr. Frank Donaldson, Jr., discussed the new plan of pneumatic inspiration, and exhibited the cabinet used. The Faculty did not become very enthusiastic over the "machine."

The election of officers resulted as follows: *President*, Dr. G. W. Miltenberger; *Vice-Presidents*, Drs. Thomas Ossie and Richard Gundry; *Secretary*, Dr. G. Lane Taneyhill; *Assistant Secretary*, Dr. Robert T. Wilson; *Corresponding Secretary*, Dr. T. Barton Brune; *Reporting Secretary*, Dr. Richard Thomas; *Treasurer*, Dr. W. F. A. Kemp. The Executive Committee and Examining Boards were then elected, the standing committees appointed by the President, and the Faculty adjourned.

MEDA.

NEW YORK PATHOLOGICAL SOCIETY.

A STATED meeting was held April 28, 1886, the President, JOHN A. WYETH, M.D., in the chair.

PREGNANCY COMPLICATED WITH UTERINE FIBROIDS—RETENTION OF URINE, AND PYONEPHROSIS.

Dr. C. C. LEE presented a specimen removed from a married woman, 37 years of age, who was admitted to his service in the Woman's Hospital on the 16th of March, with the following history. She had been married two years, had never borne children, but eight months previous to her admission had had a miscarriage at about the second month of utero-gestation: the cause of the miscarriage was not known. When admitted,

she had been ill for two months, complaining chiefly of retention of urine, with great dysuria, œdema of the lower extremities, and slight shortness of breath. It was supposed by her physician that she had an ovarian tumor. On examination she was found to be pregnant, and to have the following peculiar condition of the bladder. This organ was enormously distended with urine, extending above the umbilicus. On passing the catheter, between eighty and ninety ounces of urine were withdrawn, and the tumor subsided. After this had been done it was very easy to recognize the presence of uterine fibroids. The pregnancy was estimated to be between the third and fourth months. The uterus was displaced backward into the cavity of the sacrum, and the retroversion was so fixed that all efforts to restore the uterus were ineffectual. The fibroids were three in number, and their outlines could be distinctly made out. It was quite evident that the retention of urine had been due to the rapidly-increasing size of the fibroids, and that one of them had pushed the lower third of the bladder against the pubis in such a way as partially to close the exit for the urine. When the urine was examined it was found to be alkaline, with a specific gravity of 1012, slightly purulent, albuminous, and after the lapse of a few days it exhibited hyaline casts. The diagnosis was pregnancy, complicated with fibromata, which had produced retention of urine by pressure on the lower part of the bladder, and probably by secondary pyonephrosis. The cervix, however, had been crowded up so far that it was almost impossible to reach it, and was above the arch of the pubis, so that the question of the induction of premature labor was decided in the negative. The patient developed pneumonia on the tenth day after admission, and died with high temperature and the symptoms resulting from that disease. Whether the pneumonia was due to septicæmia or to some casual reason was not easy to determine, but it was believed possible that the patient had lost her life because premature labor was not induced. Miscarriage did not occur.

At the autopsy, the lower and middle lobes of the right lung were found in a condition of partial resolution, with a large quantity of serum in the pleural cavity of that side. The heart was flabby, but not otherwise diseased. In the abdomen the three fibroids presented themselves with the bladder drawn up over them to a great extent, and the largest of the three had caught the lower portion of the bladder against the pubis, and the fibromatous mass had also pressed the uterus into the cavity of the sacrum, thus giving an additional reason for the immovable retroversion. The uterus contained the fœtus, and presented no peculiarities. The ureters were dilated, slightly inflamed, and both kidneys had undergone extensive and rapid degener-

ation, so that only a small amount of kidney-tissue remained. The pyonephrosis was evidently of rapid development and due to the retention of urine caused by pressure upon the lower portion of the bladder by the fibroids.

Dr. LEE thought it probably a mistake that premature labor had not been in some way produced, although the condition of the parts was such as to render it almost impossible.

HEGAR'S OPERATION FOR SUBMUCOUS UTERINE FIBROID.

Dr. LEE presented the tubes and ovaries removed from a young woman who had a sessile, submucous, uterine fibroid, occupying nearly the entire fundus of the organ. Besides the loss of blood, the patient suffered with very severe pain, and had had two or three attacks of pelvic peritonitis. Dr. Lee determined to try to force the menopause by performing Hegar's operation, and he was influenced somewhat in this determination by the fact that he had in two or three cases attempted to remove the fibroid by means of the serrated spoon and with disastrous results. This patient had been ineffectually treated with injections of ergot. He found extensive adhesions, causing much difficulty in removing the tubes and ovaries, but the patient had done well since the operation.

DOUBLE PAPILLOMA OF THE OVARIES.

Dr. LEE also presented a double papillomatous tumor of the ovary which he had removed on Saturday last from a young woman who had suffered for two years from pelvic pain, increased at menstruation. Two consulting physicians had recognized a pelvic tumor which they regarded as multiple uterine fibromata, and Dr. Lee concurred in this opinion, but afterwards, on account of the severity of the pain, concluded to make an explorative incision, when he found the double ovarian tumor. The error in diagnosis was apparently due to the fact that the sac of the tumor was unusually thick, and gave no distinct sense of fluctuation. The uterus was normal. The patient was doing well.

CALCAREOUS DEPOSIT IN THE SPLEEN.

Dr. GEORGE F. SHRADY presented a specimen sent him by Dr. Hays, who removed it at autopsy from the body of a middle-aged white man who had died of typhoid fever in Charleston hospital, 1883. It consisted of a part of the outer surface of the spleen near the hilum, and was composed of either bony or calcareous matter. The specimen was referred to the Committee on Microscopy.

FREE BODIES WITHIN THE SAC OF A HYDROCELE.

Dr. WALDSTEIN presented a specimen which Dr. Lange had given him for examination. The case was one of varicocele occurring in a patient 21 years of age. After excising the same, Dr. Lange found that there

was a small hydrocele, which he incised and removed from the sac small free bodies, which, on examination, proved to be of a fibrous character with calcification. Dr. Waldstein had examined the literature of the subject somewhat, and had found that Virchow had mentioned these bodies as originating in a pure *orchitis proliferans*, and that excrescences, fibrous in nature, generally from the albuginea, became calcified, and were freed, and then were found loose in the sac. Sometimes they also originated from the hydatid of Morgagni; but such was not the origin of the specimens presented.

ANGIOMA CAVERNOSA IN THE MUSCLES OF THE THIGH.

Dr. WALDSTEIN presented a tumor removed from the outer condyle of the left femur of a girl aged 5 years. It was painful, and interfered with flexion of the knee. It had not perceptibly grown during the last two and a half years. The attachments of the tumor were uncertain, but Dr. Sands and Dr. Waldstein were of opinion that it was situated within the muscle, and this view was confirmed at the operation for its removal, which was performed by Dr. Sands. The growth was found to be situated within the belly of the muscle, surrounded by a fibrous capsule, which was easily enucleated, except at its attachment at the lower extremity of the muscle. The muscular tissue in the neighborhood of the tumor had perceptibly degenerated. The tumor was found, on microscopical examination, to be an angioma cavernosa.

The PRESIDENT had a similar specimen which he had removed from the vastus internus muscle. He operated without hemorrhage by the application of an Esmarch bandage; but a surgeon who had undertaken to remove it previously had abandoned the operation on account of profuse hemorrhage.

REVIEWS AND BOOK NOTICES.

CANCER. A STUDY OF THREE HUNDRED AND NINETY-SEVEN CASES OF CANCER OF THE FEMALE BREAST. With Clinical Observations. By WILLARD PARKER, M.D. G. P. Putnam's Sons, New York and London, 1885.

For several years before his death, Professor Willard Parker was engaged in the task of arranging and classifying the cases of mammary cancer that had come under his observation, amounting in all to nearly four hundred. Although the work had been completed, his failing health prevented him from doing much in its revision. In accordance with his wish, the record has been published, —not, however, as an elaborate work, but

merely as the embodiment of practical observations and conclusions reached during a long and busy professional life by one who, with exceptional opportunities for experience, was endowed to an unusual degree with sound and cultivated judgment and extraordinary powers of observation. The matured opinions of such men deserve serious consideration.

Dr. Parker regards the process of the formation of cancer-cells as a process of mal-assimilation. The cancer-cell, it is claimed, probably has the power of producing its like by assimilating the nutritious elements of the blood, as other tissues have, and it may be considered as having a life peculiarly its own. Not having, however, a normal function to perform like other cellular tissues, it is not, like them, subject to wasting metamorphosis; and therefore it tends to keep adding to its bulk by reproducing itself, and by causing through infection a growth similar to itself in adjacent healthy cellular elements. The view is held by the writer that connective tissue may develop cancer-cells; that the epithelium of gland-structure may develop cancer-cells; and that cancer may proceed from any epithelial structure. But all these views are considered quite insufficient when they seek to limit the cancerous proliferation to the epithelium or to the connective tissue. In the cases examined, both breasts were affected in fourteen cases; in the others there was a slight preponderance in favor of the right breast (one hundred and seventy-four to one hundred and eighty-nine). The age at which in the greatest number of patients the disease begins is from forty to fifty. As to duration, experience indicates that the greatest number of deaths from cancer occur after the first year and before the end of the second year of the cancerous development. Mammary as well as other varieties of cancer has a traumatic exciting cause. The lesson is also taught that there is such a strong disposition among certain individuals to cancer as to warrant holding the opinion that there is a cancerous diathesis.

According to the author's observation, cancer is the most prevalent among peoples that are in the habit of living generously and addicted to luxurious habits, more particularly to eating highly-seasoned food, and who are more or less troubled with mal-assimilation, and consequently sympathetic irritation of the skin and mucous membrane. In the causation, anxiety, care, trouble, and sorrow may be assumed as exerting some influence, and the hypothesis is favored that cancer has for one of its causes mental affliction. Heredity exerts a much smaller influence in the production of tumors than is popularly believed. The effective causes of cancer, then, may be summed up as (1) luxurious living, (2) local irritation of an epithelial surface, (3) mental affliction, (4) dysmenorrhœa and

other uterine irregularities. In treatment, a carefully-regulated diet is of primary importance. The latter portion of the *brochure* is devoted to the detailed tabulated account of the three hundred and ninety-seven cases, with notes of treatment.

TRANSACTIONS OF THE ACADEMY OF MEDICINE IN IRELAND. Vol. III. Edited by WILLIAM THOMSON, M.A., F.R.C.S. Dublin, 1885.

This handsome volume of Transactions contains papers which are all of interest and some of decided value. The Pathological Section contains twenty-three articles, one of the most interesting being the report of a case of epithelioma resulting from irritation by crude carbolic acid, by Mr. Story, and one of tar-cancer by Mr. Ball. Mr. Wheeler has a successful case of removal of sarcoma of the anterior abdominal wall. In the Section on Medicine is a very valuable paper by Surgeon-Major Hamilton on cholera. Dr. Walter Smith's article on lupus, and Dr. Cruise's notes on Contrexéville and Royat Les Bains, are also noteworthy. The Surgical Section has comparatively few papers; but attention is attracted by the contributions of Mr. Ball on Melanotic Sarcoma of the Rectum, Mr. Franks on the Treatment of Flat-foot, and Mr. Thornley Stoker on Internal Urethrotomy.

APPLIED OR MEDICAL CHEMISTRY. A Manual for Students and Practitioners of Medicine. By LAURENCE WOLFF, M.D., Demonstrator of Chemistry, Jefferson Medical College, etc. Philadelphia, P. Blakiston & Co., 1885. 8vo, cloth, pp. 174.

This Manual consists of five sections, with an appendix. Part I. is devoted to Apparatus and Manipulations; II., to the Chemistry of Poisons; III., to Physiological Chemistry; IV., to Excretions and Concretions; and V., to Sanitary Chemistry; the Appendix containing a note on ptomaines, and tables.

This is a comprehensive and convenient hand-book for the student and the practitioner. A valuable feature in the work is the syllabus at the end of each chapter. Taken as a whole, it forms a practical, short course in medical chemistry, embracing such subjects as all medical students should be required to be familiar with before receiving their degree.

NEW REMEDIES AND CLINICAL NOTES.

DR. HOLMES'S TOAST TO THE DENTISTS. —In declining an invitation to dine at the Hotel Brunswick with the New York Odontological Society recently, Oliver Wendell

Holmes wrote, "I often think of the forlorn conditions of some of the great personages of history in the days when there were no dentists, or none who would be recognized as such by the dental artists of to-day. Think of poor King David, a worn-out man at seventy, probably without teeth, and certainly without spectacles. Think of poor George Washington, his teeth always ready to drop like a portcullis and cut a sentence in two. See him in Stuart's admirable portrait, his thoughts evidently divided between the cares of empire and the maintenance of the *status quo* of his terrific dental arrangements. Think of Walter Savage Landor's melancholy complaint that he did not mind losing his intellectual faculties, but the loss of his teeth he felt to be a very great calamity.

"I will venture to propose, then, the dental profession, and their association as its worthy representative: it has established and prolonged the reign of beauty; it has added to the charms of social intercourse and lent perfection to the accents of eloquence; it has taken from old age its most unwelcome feature, and has lengthened enjoyable human life far beyond the limit of years when the toothless and purblind patriarch might well exclaim, 'I have no pleasure in them.'"

HYDROGEN PEROXIDE IN ALVEOLAR ABSCESS.—Dr. G. W. Smith, of Cincinnati, read a paper before the Mississippi Valley Association on the use of hydrogen peroxide in dentistry, in which he reported very satisfactory results from the treatment of chronic alveolar abscess with injections of this agent. The curative effects were decided and prompt. He also found it invaluable in the treatment of Riggs's disease of the gums, in which the alveolar processes are subject to destructive suppurative inflammation.—*Dental Register*, April, 1886.

MISCELLANY.

THE AMERICAN MEDICAL EDITORS' ASSOCIATION held its annual meeting May 3, at the St. Louis Press Club. After an address by the President, H. O. Walker, M.D., of Detroit, the editors sat down to dinner as the guests of the Medical Press and Library Association. J. V. Shoemaker, M.D., of Philadelphia, was elected President; Dudley Reynolds, M.D., of Louisville, Kentucky, Vice-President; and William Porter, M.D., of St. Louis, Secretary. This was the most successful, harmonious, and enjoyable meeting that the Association has ever held, owing to the cordiality of the local medical press.

DR. W. A. M. CULBERT, Newburgh, New York, says, "Colden's Liquid Beef Tonic is an excellent article for the purposes for which it

is offered. I recall patients by whom it was taken with eagerness and great benefit after domestic beef-teas and other beef-preparations had become repulsive."

THE AMERICAN CLIMATOLOGICAL ASSOCIATION held its annual meeting in this city during the week. A report of its proceedings will appear in our next issue.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U. S. ARMY FROM APRIL 25, 1886, TO MAY 8, 1886.

MAJOR HENRY R. TILTON, SURGEON.—From Department of the East to Department of California.

MAJOR JOHN BROOKS, SURGEON.—From Department of California to Department of the East.

CAPTAIN EDWARD T. COMEGYS, ASSISTANT-SURGEON.—From Department of Missouri to Department of the East.

CAPTAIN AARON H. APPEL, ASSISTANT-SURGEON.—From Department of the East to Department of Missouri. S. O. 106, A. G. O., May 6, 1886.

MAJOR FRANCIS L. TOWN, SURGEON.—Granted leave of absence for eight months, with permission to go beyond sea, to take effect when his services can be spared by his department commander. S. O. 101, A. G. O., April 30, 1886.

CAPTAIN JOSEPH K. CORSON, ASSISTANT-SURGEON.—Granted ten days' extension of leave of absence granted in Orders No. 79, April 15, 1886, Jefferson Barracks, Missouri. S. O. 97, A. G. O., April 26, 1886.

CAPTAIN WILLIAM J. WILSON, ASSISTANT-SURGEON (Plattsburg Barracks, New York).—Granted leave of absence for one month, on surgeon's certificate of disability. S. O. 25, Division of the Atlantic, April 27, 1886.

CAPTAIN WILLIAM J. WILSON, ASSISTANT-SURGEON.—Died, May 2, 1886, at Plattsburg Barracks, New York.

CAPTAIN ROBERT B. BENHAM, ASSISTANT-SURGEON.—Ordered from Department of Texas to Department of Dakota. S. O. 97, A. G. O., April 26, 1886.

FIRST-LIEUTENANT GEORGE F. WILSON, ASSISTANT-SURGEON.—Ordered for duty at Fort Shaw, Montana Territory. S. O. 37, Department of Dakota, April 26, 1886.

FIRST-LIEUTENANT A. S. POLHEMUS, ASSISTANT-SURGEON.—Relieved from duty at Presidio of San Francisco, California, and ordered for duty as post-surgeon, Fort Halleck, Nevada. S. O. 28, Department of California, April 26, 1886.

LIST OF CHANGES IN THE MEDICAL CORPS OF THE U. S. NAVY FROM APRIL 25, 1886, TO MAY 8, 1886.

ASSISTANT-SURGEON F. W. F. WIEBER.—Detached from Receiving-ship "Vermont," and ordered to the "Hartford."

ASSISTANT-SURGEON ELMER C. TRACY.—Ordered to the "Vermont."

PASSED ASSISTANT-SURGEON J. R. WAGGENER.—Detached from the "Hartford," and ordered to the "Iroquois."

SURGEON J. F. BRANSFORD.—Detached from the "Iroquois," to proceed home and await orders.

ASSISTANT-SURGEON ISAAC W. KITE.—To duty at Naval Hospital, Brooklyn, New York.

ASSISTANT-SURGEON ISAAC KITE.—Ordered to Naval Hospital, Brooklyn.

PASSED ASSISTANT-SURGEON W. J. SIMON.—Ordered for temporary duty to the Naval Academy, Annapolis.

PASSED ASSISTANT-SURGEON GEORGE C. LIPPINCOTT.—Ordered for temporary duty to the Naval Academy, Annapolis.